A Study of Physician Preparedness in Relation to Religious Diversification: Examination of Policy, Education, Training, and Experience

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Abstract

Due to increasing religious diversification in the United States over the last few decades, many businesses and public and private institutions are seeking to better understand and accommodate the needs of those who claim some form of religion, spirituality, belief, or faith. However, one context that appears to be slow in responding to this rapidly diversifying landscape is the hospital, a vital part of the healthcare system. While a patient's religion and spirituality have been shown to play a beneficial role in recovery, overall health, and treatment success, initial research indicates many physicians are not adequately prepared to address this dimension of patient care. Given the critical role of the physician in patient health, it is imperative to evaluate their training and preparation to accommodate patient needs in relation to religion, spirituality, belief and faith. In this study, it will be demonstrated that more standardized medical school training, uniform hospital policy, and further research into religious and cultural competency are needed to better prepare physicians to meet the religious and spiritual needs of their patients. The value of this greater awareness and accommodation not only fulfills a physician's duty to treat a patient's condition, but also provides a way to care for patients more holistically and in a non-discriminatory fashion.

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Chapter 1: Defining the Focus of this Study and its Ramifications

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Explaining Current Medical Practice in the Face of Changing Religious Diversity

Medical advancement has typically been a product of the time and place in which it exists. For example, the ancient Greeks pursued cultural, philosophical and scientific advancement to develop a disciplined society. The physician Hippocrates sought to instill a deep tradition and standard of practice among his practitioners using the Hippocratic Oath. Gene research is another instance demonstrating the evolution of health practice; just as modern culture seeks to push boundaries in art, expression, and style, medicine has developed technologies that can not only read an individual's genetics, but alter them to change a person's appearance, mental state, or health.

While many of the well-known norms in medicine have arisen due to scientific discovery and development, it must be pointed out that medical practice is also influenced by other factors, such as cultural, religious, and societal norms. Consider the changes in cultural diversity over recent years. Significant improvements in global communication, global awareness, migration, and transportation have increased immigration and travel between many countries, transplanting people with new cultures and ideas to completely different continents. Arguably one nation most visibly affected by this diversification is the United States. For example, a 2017 executive survey conducted by the Public Religion Research Institute found that only 43% of Americans identify as white Christian. This is a stark contrast from 1976 when 81% of Americans identified as white Christian. Furthermore, the Institute found that in non-Christian religious groups in America, such as Islam, Buddhism, and Hinduism, over 30% of each group is under 30 years of age. Compared to white Protestantism, which has 11% of the population under 30 years old, the

population of non-Christian citizens is expected to increase in the coming years (Cox & Jones, 2017). In sum, major shifts in religious trends in the United States have occurred in the last fifty years, and the data indicates the shift will only continue. In response to this changing diversity, some organizations and institutions have begun developing certain practices, policies, and guidelines to meet the needs of clients and employees. An example of such accommodation is the establishment of multi-purpose rooms in busy major airports to allow participation in prayer, worship services, meditation, and other practices (Sandstrom, 2015). The American healthcare system also provides evidence of this accommodation. Hospitals typically employ the use of chaplains to meet the religious and spiritual needs of patients and their communities; additionally, there are often chapels and other spaces set aside for religious purposes. However, while the job of chaplains is to support the religious and spiritual well-being of patients in the medical environment, these professionals are not always in constant contact with all hospital patients; this is not the case with physicians who work in closer proximity to patients and are sometimes called upon in situations related to patient religion and spirituality. This can present a challenge to physicians who are not traditionally considered religious guides in the professional capacity. One 2012 study conducted at six American medical centers found that 33% of non-terminal patients surveyed wanted to have a religious discussion with physicians and nineteen percent of surveyed patients wanted their physician to pray with them. When patients were terminally ill, both percentages increased dramatically (Saguil & Phelps, 2012).

With the diversification of the workforce and changing government and workplace policies regarding religious accommodation, religious awareness is becoming a prominent issue more generally. Furthermore, with major differences between hospital infrastructure and religious affiliation, uncertainty about training in religious and spiritual literacy in medical

schools, and relatively vague policy in this area of medicine, it can be difficult to understand how physicians are being trained regarding religious and spiritual accommodation. Thus, it is important to research and evaluate whether physicians are being adequately prepared to meet the religious needs of their patients, both in their medical training, and in terms of hospital policy, and support.

Religion, Spirituality, Faith, and Belief in the Context of Healthcare

At the outset, it is important to identify the meaning of religion and spirituality as they relate to the patient experience. Ozden Dedeli and Gulten Kaptan briefly identified discrepancies between the terms in their background material of a study on religion and spirituality in medical pain management. As both professionals are experienced medical care providers well versed in these topics, their definitions seem appropriate for the purposes of this 2013 study. Spirituality is designated as an "experience of transcendence, connectedness, meaning, and purpose in life, integrating aspects of the self or the search for the sacred". The authors further explain that the concept of spirituality can entail a more individualized approach to sacred concepts or higher beliefs. Meanwhile, religion is defined as "a set of beliefs and practices around the existence of something sacred or divine" (Dedeli & Kaptan, 2013). The assumption made is that religion pertains to the beliefs and practices of religious communities. The authors also point out that the concepts of religion and spirituality tend to be exclusive but may also be related. A patient can be religious as an expression of spirituality, for example; conversely, a person can consider themselves religious but not necessarily be spiritual. The complex relationship shared by these two factors presents an issue in defining a patient's religion and spirituality in terms of a single

concept. In fact, studies concerning religion and spirituality in the medical setting tend to use both terms together.

It should be noted the term "faith" is not a commonly used word in professional medical research. This is possibly a result of the arbitrariness of meaning to different groups and individuals, as well as its Protestant Christian connotations. In some contexts, faith is considered a belief in a higher power and a belief in particular doctrine in other contexts (Merriam Webster, 2020). In perhaps a more general definition, faith can indicate "something believed with strong conviction" (Merriam Webster, 2020). Thus, the varied meanings of faith make the identifier unreliable to this study. Therefore, usage of the term as a descriptor will be minimized to prevent confusion.

Due to the frequency of the terms "religion" and "spirituality" in professional research and less consistent use of "belief" and "faith" in the literature, the remainder of this study will use "religion and spirituality" as a representative phrase to indicate patient religion, spirituality, faith, and/or belief. The only exception to this pattern will be use of different phrasing if it is used by and is pertinent to a specific cited research article.

The Relevance of Community in Relation to Religion and Spirituality

While a patient's religion and spirituality is frequently viewed from an individual perspective, there is also the social aspect in the form of religious communities or spiritual groups. Regarding healthcare, these communities might have a significant impact on patients' religious or spiritual needs. A recent 2020 article by Basem Attum et al. provided examples of traditional Muslim practices that healthcare providers needed to be aware of to ensure proper care of their patients: modesty, touch restrictions, and privacy to name a few (Attum, Waheed, &

Shamoon, 2020). Therefore, the importance of values held by religious and spiritual communities can be just as significant a factor in care as the patient's individual religion and spirituality in the hospital setting.

Why Does This Study Matter? Need for Religious Accommodation within the Hospital

As religious diversity is expected to continue to grow over the next few decades, pressures to attend to religious needs in the hospital context are growing. Issues such as the religious right to refuse care are sensitive topics that are hotly debated and require much consideration. However, the focus of this study does not deal with specific religious controversies, but rather the ramifications of such pressures on the medical environment. This is well illustrated in the account of one physician who wrote an article about his personal experience; in this article, the physician Robert Klitzman discusses a time when he felt unable to provide help for a terminally-ill patient or to seek assistance from a hospital chaplain. The physician notes a time that he felt ill-educated to help a patient needing religious and spiritual guidance and he was worried about making a mistake. In addition, Klitzman noted a distinct gap between the doctors and spiritual counsellors stretching as far back as medical school that made it more difficult to seek help in this aspect of patient care; he claims this gap was created by limited exposure to the chaplain profession early on in physician education. While this article relates to one specific case, other evidence suggests this perceived deficiency is more widespread. Studies have shown that only 72% of all patients felt a medical institution provided needed spiritual help (Klitzman, 2015). While policies like religious literacy are becoming more emphasized in areas like college education in the United States (AAR Religious Literacy Guidelines, 2019), there is not much direct research investigating if physicians are adequately

being equipped, trained and prepared to encounter religious and spiritual needs in the hospital setting. To better understand the details of the issue as it pertains to this entire study, the next chapter will examine the relevance of religion and spirituality in the patient experience.

Chapter 2: Approaching the Patient Experience from the Perspective of Religion and Spirituality

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The Role of Religious and Spiritual Practices in Patient Health/Recovery

From disease study to medical trials, the value of scientific study is integral to the advancement of medical practices. The National Center for Biotechnology Information, a government organization recording and tracking research, cites that as of 2009 there were 10,974 ongoing clinical trials, recruiting at least 2.8 million participants. According to the article, over 50% of these studies were drug trials designed to develop new medications for treatment of various disorders and diseases (The State of Critical Research in the United States: and Overview, 2010). Furthermore, a 2018 study by Johns Hopkins found that the median cost to develop a new drug was $19 million, with some large-scale studies spending $157 million or more (Cost of Clinical Trials for New Drug FDA Approval Are a Fraction of Total Tab, 2018). While examination of new drugs is important to improving patient care, some recent studies have begun researching the value of religion and spirituality regarding patient recovery and progress. Based on these studies, religion and spirituality appear to fulfill a few different roles that support patient health.

The first area where religion and spirituality can have an impact is alleviation of patient sense of suffering. A pain questionnaire mentioned in a 2001 NCBI article concerning health care and spirituality found that of all patients surveyed, 76% used prayer to cope with pain, as opposed to only 66% using pain medication (Puchalski, 2001). Many patients experience suffering in one form or another during their experience in a hospital; suffering can come in many forms, such as feeling of helplessness, anxiety, mental depression, and physical pain. To better evaluate religion in the context of pain relief, Baetz and Bowen conducted a 2008 study on 37,000 participants suffering from chronic pain issues; they found that in that group, participants suffering from chronic pain were more likely to engage in religious practices such as prayer. Furthermore, the participants with pain who practiced different forms of religion and spirituality on a regular basis were more likely to be psychologically healthy (Dedeli & Kaptan, 2013). Another study in 2015 by Dezutter et al. examined chronic pain in a more detailed study of practice. Researchers sent questionnaires to chronic pain participants and healthy participants, using Literal and Symbolic Inclusion-Exclusion scales that encompassed a more nuanced definition of spiritual connection. The study found that individuals rejecting religious concepts (Literal Exclusion) in the chronic pain group tended to have a lower wellbeing while individuals more accepting of religious reality, symbolic inclusion and symbolic exclusion, tended to have a higher average of wellbeing in the chronic pain group (Dedeli & Kaptan, 2013). Baetz and Bowen's study generally indicated there was a larger tendency to demonstrate religion and spirituality in groups with chronic pain, and Bezutter's study concluded chronic patients more accepting of religious ideas or principles were more likely to present better wellbeing. Bezutter also alleged that being open to religious ideas stimulated a sense of purpose which can buffer the perception of pain. This conclusion is like that of Viktor Frankl, a Jewish psychologist

imprisoned in Nazi labor camps. Frankl famously noted in *Man's Search for Meaning* "' Man is not destroyed by suffering: he is destroyed by suffering without meaning'". Frankl proposed this theory after observing fellow prisoners in the camps; in one example, he mentioned a man who prayed his sacrifice might keep his loved ones from the same fate (Frankl, 83). While a patient in a hospital is not the same as a Jewish prisoner in a concentration camp, the principle Frankl portrayed is grounded in the principle of logotherapy, a theory that people seek meaning above all else, including above pain (Frankl, 113). Studies on the effectiveness of Frankl's logotherapy revealed that having some perceived meaning or drive improved not only sense of purpose, but levels of depression in participants (Robatmili et al., 2015). From Frankl's viewpoint, religion appeared to positively affect perception of pain and suffering by providing a perceived greater purpose that superseded the experience of pain.

Though briefly alluded to in the previous paragraph, religious and spiritual practices also serve another vital role in the providing hope to patients. Hope is often difficult to define as it can mean vastly different things to different people. Even for those without belief in a deity or higher power, hope can manifest as a desire to leave a great legacy and impact on future generations. Regardless of the individual, however, it is likely most people would identify some form of hope they have in their life if asked; looking at the effects of hope on patient treatment, it is clear to see why so many people possess it. A 2003 study by Ryden found that undergraduates with a positive attitude due to hope for success lowered the risk of psychological distress and health complications in college (Duggal, Sacks-Zimmerman, & Liberta, 2016). This can apply to general health as college shares many stresses with post-graduation experiences. Furthermore, per Alexander Muacevic, hope is often characterized by optimistic outlook and attitude, attributes shown to correlate with increased immune system response and cardiovascular

function (Duggal, Sacks-Zimmerman, & Liberta, 2016). Finally, positivity and optimism have been studied in conjunction with heart transplant and cardiovascular operations, the resulting data indicating hope can increase the chance of successful procedure and recovery (Duggal, Sacks-Zimmerman, & Liberta, 2016). Observing this data, there appears to be a strong correlation between hope and patient recovery. Furthermore, hope also could be considered a protective factor as the positive mood associated with it prevents stress-related disease and depression (Duggal, Sacks-Zimmerman, & Liberta, 2016). Possessing hope does not guarantee better patient health in every case, and correlation of the data mentioned does not necessitate causation. However, correlation in this case provides strong indication that hope can provide patients a feeling of security that assists in decreased risk of worsening illness or increased resilience to certain ailments.

A final function of patient religion and spirituality focuses more on the community surrounding a religious or spiritual system. According to the National Institute on Aging as of 2019, social isolation and loneliness have been linked to health conditions such as depression, high blood pressure, weakened immunity, cognitive disorders, and anxiety (Social isolation, loneliness in older people pose health risks, 2019). According to the same organization, over 11.3 million elderly individuals live alone in the United States and this population is expected to grow as life expectancy increases (Read how IOA views aging in America, 2018). To combat the possible negative outcomes of loneliness on this vulnerable population, studies were conducted on the importance of company and visitation in the hospital. Brit Trogen from *The NYU Langone Health Journal Online Journal of Medicine* mentions a plethora of research correlating open visitation policy to faster recovery (Trogen, 2018). The value of such studies show the importance of meaningful social interaction in the medical setting. Such interaction can occur

from several relationships: social integration may be considered an overarching term that encompasses many relationships found in a community (Jeannotte, 2008). Understanding that social integration can entail the concepts of social inclusion and cohesion, one can understand the implications of the study conducted by the National Social Life Health and Aging Project. According to data collected by the organization in 2013, religious attendance or practice is associated with higher levels of social integration, leading to lower tendencies toward loneliness (Rote, Hill, & Ellison, 2013). Such integration through religious communities could have profound impact in reducing loneliness and promote better health.

After examining the potential impacts of religion and spirituality in patient recovery, there appear to be many quantitative and qualitative benefits to increasing awareness of these issues. That being said, an idea not yet considered is the possible implications of these benefits for non-religious patients. For instance, a non-religious patient might ask for prayers to promote their own mental health or give them a sense of connection. This shows that religion and spirituality can have a positive impact on patients, despite their religious or spiritual stance outside of the hospital. Acknowledging this possibility is important to fully understanding the role of religion and spirituality in healthcare.

The Physician's Role in Patient Religion and Spirituality

Now that the role religion and spirituality can play in patient health has been discussed, the role of physicians can now be examined in the capacity of spiritual provider or assistant. First, one must examine the duties assigned physicians by the U.S. governance system. According to the U.S. Bureau of Labor Statistics, a physician or surgeon is required to perform the following procedures: take patient medical history, update health information, order testing

for ailment identification, create a tailored treatment plan, address patient concerns or questions about health and wellbeing, and discuss health topics with patients (Physicians and Surgeons). These duties are the quintessential core of physician responsibility, regardless of specialty or area of expertise. While these requirements primarily act to establish the physician in a prominent position to look after a patient's physical wellbeing, the requirements arguably entail supporting a patient's religious or spiritual wellbeing. Examining some of these duties in greater detail supports this hypothesis.

First and foremost, a physician is the individual primarily responsible for the patient's health and well-being. Using all the data presented from various tests and patient histories, the physician builds a tailored treatment plan that meets the needs of the patient. In permitting a physician to access their records and develop a plan that profoundly impacts their life, the patient conveys a certain degree of trust supplemented by a physician's ethical obligation to their patient (Patient-Physician Relationships). Trust can deeply impact how physicians are perceived by their patients; in the U.S. in 2012, physicians ranked third in the most trusted professions, above lawyers, teachers, and many other professionals (Collier, 2012). This trust can translate to matters not directly related to physical wellbeing. As mentioned earlier in this study, at least 33% of patients want their physician to discuss religious matters and speak with them about their religious beliefs (Saguil & Phelps, 2012). It appears from this data that some patients want physicians to play a role in their spiritual life while undergoing treatment.

Another aspect of the physician's role is to discuss health related topics necessary for patient improvement and answer any questions regarding such health topics. Again, the most direct application of this duty is communicating physical treatment plans to improve patient health. However, based on previously covered material, religion and spirituality are being

increasingly studied in a medical context to explore their potential impact on health improvement. With compelling research showing positive correlations between religious and spiritual practice and health outcomes, supporting a patient in such matters could fall under the duty to informing patients and supporting opportunities for health improvement.

Identifying Religious and Spiritual Boundaries for Physicians in Medical Contexts

So far, the argument is that physicians should be better trained to meet the needs of patient religion and spirituality. However, it is important to acknowledge that there are valid viewpoints arguing that physicians should perform no such function in a medical context. Dr. Richard Sloan wrote an article shared in the *AMA Journal of Ethics* that focusses on reasons physician involvement in non-medical areas is a bad precedent, both ethically and logically.

First, the article argues that physicians are not formally trained for complex religious situations and are therefore underqualified to assist in patient religious or spiritual need. Sloan raises the point that chaplains are much more qualified and should be used in difficult religious and spiritual situations. Second, Dr. Sloan also argues that there are ethical implications of increased focus on patient religion and spirituality. One concern is that increased conversation on religion and spirituality may lead to physician's personal beliefs impacting how they care for patients. He cites a Christian-based society that advocates for Christian evangelism enabled by professional interactions with patients as an example of an unfair pressure on a vulnerable population. Another ethical implication Dr. Sloan argues is that discussion of a patient's religion and spirituality could be considered an invasion of privacy in some cases. Finally, the physician argues that attention to patient religious or spiritual matters, while important, can take time and effort better allocated to the treatment of patients. The concern is that physician time with

patients will be further narrowed by the introduction of policy on religious awareness (Sloan, 2019).

Dr. Sloan makes many compelling arguments that appear to present a conflict with the rest of this study thus far. However, one may also see these concerns as potential boundary setting markers should physicians continue to work toward more accommodation of patient religious and spiritual needs. For example, while physicians are not professionally trained to handle more complex religious and spiritual situations, such as discussing end of life subjects with patients and family, training in medical school could be changed to help physicians identify these difficult situations and seek assistance from pastoral care or other resources to resolve the issue. Regarding ethical implications, loss of autonomy is a real threat in many aspects of medicine. Just as a physician's medical actions are regulated by ethical policy, the actions of healthcare providers in religious or spiritual matters would also need to be regulated by ethical boards and enforced by law. Finally, if adding religious and spiritual considerations is a concern regarding time spent with a patient, it would be important to develop inherent skills in religious literacy or comprehension to facilitate easier and faster action of physicians in such situations.

Chapter 3: Evaluating Physician Instruction, Training, and Experience

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Medical School Instruction on Religious Competency, Religious Literacy, and Ethics

Medical schools are highly respected as centers of physician training and preparation. In fact, these graduate programs have extensive requirements to even be considered for acceptance,

including a specific standardized exam, specific course prerequisites, and a certain level of academic caliber (Medical School Requirements. The Definitive Guide). These prerequisites are designed to prepare students for the lengthy and intense training covered by the teaching process. By evaluating the training programs implemented by some prominent medical schools, focusing mainly on religious education, one can get a sense of how current physicians are being instructed in meeting patients' religious and spiritual needs.

The American Medical Association is an influential national organization concerning medical education and training. The program is designed to improve American medical practice through legislation and information. For example, the association publishes the *AMA Journal of Ethics* that deals with current ethical issues. Because of its influence, the association has some control over curriculum and training in medical schools. Regarding the relationship between medicine and patient religion and spirituality, the program has made strides to incorporate more standardized and advanced education in religious awareness in a medical environment. In medical schools, the organization has begun focusing on what it calls "cultural competency" (Cultural Competence Education, 2005). This concept is a broad perspective on instruction, entailing physician understanding of not only religion and spirituality, but cultural background in patient health. To standardize instruction on cultural competency, the AMA implemented the Tool for Assessing Cultural Competence Training, or TACCT, in 2005. TACCT is an assessment checklist of sorts that represent the basic criteria for cultural competency education in students. The tool was designed to spot weak areas in curriculum to be supplemented or altered by each medical school. However, while the list of required skills is quite lengthy, only 5 of the 24 total parameters pertain directly to religion and spirituality. Furthermore, the AMA explicitly states that while TACCT principles are required in curriculum, the amount of time devoted to the

material covered and the way in which the material is conveyed is completely dependent on the medical school (Cultural Competence Education, 2005). The arbitrariness and freedom afforded medical schools in this area is concerning as different medical schools could teach religious competency in very different ways; one school might heavily emphasize instruction on religious accommodation while another might barely touch on the subject. However, the AMA appears to be showing more and more attention to the religious and spiritual aspects of competent care. For example, the *2018 Journal of Ethics* included a thorough study of religion and spirituality in medicine, even including numerous case studies most commonly encountered by physicians: involvement in patient prayer, conflict between personal belief and other outside beliefs, and working through religiously and spiritually-controversial medical practices were all discussed, providing guidance and reasoning for the professional physician (Cook et al., 2018). The *Journal of Ethics* is a renowned and accessible source of up to date information for all medical professionals. Highlighting the importance of religion and spirituality in this article indicates a growing attention onto that area of care on the part of the AMA.

While overarching organizations like the AMA have some influence over curriculum and training, examining medical school curricula provides a more realistic perspective on physician training. For example, in the upcoming academic calendar for the class of 2021 at George Washington University, the first year is devoted to the study of foundational themes, immunology, cardiology, renal, pulmonary, gastrointestinal systems, and the liver. Likewise, the second year covers central nervous system, endocrine, reproductive systems, elective courses, and foundations of clinical practice. The next two years of study mainly entail experiences in a clinical setting. While these courses are undeniably important in the training process, no course appears related to discussion of religious literacy or interaction with patient religion and

spirituality (Structure and Schedule). However, while no courses are listed that explicitly engage religious or spiritual issues, there is a possibility that these may be a subsection of a larger course, just as education about the religious and spiritual aspects of patient care were only a subtopic in cultural competency. According to a study highlighted by Kellie Rowden-Racette in a 2009 article, while 80% of medical schools conducted some form of education on spirituality, many programs taught these topics as a minor feature of overall physician bedside manner (Rowden-Racette, 2009). Other sources assert that many spirituality-based courses are featured as elective courses rather than required material (Bellwood, 2015). Considering some of these perceived deficiencies in religious and spiritual instruction, some research has been conducted among medical students and faculty to better convey the role physicians play in patient's religious and spiritual needs. In their 2016 study, "Developing a Medical School Curriculum for Psychological, Moral, and Spiritual Wellness: Student and Faculty Perspectives", Christine Mitchell et al conducted interviews among junior and senior Harvard Medical School students, Harvard Medical faculty, and graduate Harvard Divinity students. Through a series of prepared questions, participants conveyed what style of instruction on religious and spiritual relevance in medicine would best promote awareness and preparedness in new physicians. Both medical students and faculty generally agreed that a religion and spirituality course would likely be more effective longitudinally, provided over multiple years of schooling to provide retrospect and reflection. However, much of the same group indicated that religion and spirituality courses should not necessarily be required, but be elective. While this may seem counterproductive, one faculty member pointed out that making the curriculum required would likely help ensure physician preparedness in religious and spiritual situations. Finally, students agreed that a course in religious and spiritual material would be much more appealing if taught experientially rather

than lecture-based. They argued the experience provided more real-life exposure that better conveyed the application of the lessons (Amobi et al., 2016).

Hospital Policies Supporting the Exercise and Freedom of Patient Religion and Spirituality

Physician training in religious and spiritual issues and topics in medical school is a cornerstone to enabling physician competency in those situations. However, just as a physician is impacted by their training, their abilities are also heavily influenced by the policies set forth by their respective medical center or practice. Hospitals are an ideal focus in this study as they treat can treat a wide variety of patients depending on location, offered treatment, and connection to the community. Because hospitals are created to serve a community or region on a larger scale than smaller private practices, hospitals have a duty to exhibit non-discriminatory and considerate care when treating patients of various nationality, religion, spirituality, or culture. As such, hospitals likely have the most defined policies on religious and spiritual matters among local healthcare institutions. However, in examining American hospitals, there appear to be many differences from facility to facility that can impact policy. The most distinctive structural division between different hospitals is likely the difference between private and public hospitals. While private facilities are funded primarily funded by a private sector group or leader, public hospitals are government-funded. The private system typically is associated with more personalized and higher cost care, making them more favored by affluent clientele. Conversely, public hospitals in general do not have as much funding and are often affordable, making them more available to people with low income or restricted insurance coverage (What is the Difference Between a Public and Private Hospital?). The second difference that is more relevant

to this study is the foundational values of the hospital. In the United States, it has been estimated that 40% of inpatient beds are installed in religiously-affiliated hospitals (Overview: Restrictions on Health Care at Religiously Affiliated Medical Facilities). Furthermore, due to their religious affiliation or foundation, some hospitals reserve their right to perform or not perform certain procedures; the American Civil Liberties Union mentions, for instance, that Catholic affiliated facilities ascribe to the Ethical and Religious Directives for Catholic Health Care Services, which can impact care concerning counseling, birth control, and even end-of-life proceedings (Overview: Restrictions on Health Care at Religiously Affiliated Medical Facilities). Due to the high level of variability in hospital characteristics, examination of hospital policies for the sake of this study will focus primarily on national laws or policies that are more likely to impact all hospitals, regardless of their variations in mission and infrastructure. Some of these policies are examined in the remainder of this section of the chapter.

One practice considered a useful tool in large scale medical environments is the use of "spiritual assessment". Designed like a medical history, a spiritual assessment consists of asking patients questions regarding their religious affiliation and beliefs, as well as addressing any possible religious or spiritual concerns they may have about their care. The purpose of this is to reduce tension physicians may feel in discussing such issues and provide an outlet for discussion of this aspect of patient treatment (Saguil & Phelps, 2012). Dr. Giancarlo Lucchetti et al. described a few prominent spiritual assessments used in the United States in their 2013 article on the topic: FICA, HOPE, and FAITH assessments. According to Lucchetti, the quintessential goal of spiritual assessment is to better understand how a patient's religion and spirituality plays a role in their health and recovery process. Hospitals are required to conduct a spiritual assessment on patients by order of the Joint Commission on Accreditation of Healthcare Organizations.

However, it should be noted that while spiritual evaluation is required in hospital settings, there are at least 25 assessments available for use (Lucchetti, Bassi, & Ganero Lucchetti, 2013).

Another feature found in some hospitals is a department dedicated to religious and spiritual service. These organizations are often widely varied in establishment, some known as "pastoral services", others are called "spiritual services". This could include chaplain services, pastoral care, or some other variation on the title. While this study is focusing on the resources and training available to physicians, it would be remiss to neglect the function of chaplains and spiritual professionals as a resource. Hospital chaplains are trained as religious or spiritual assistants for patients, but they are often also trained specifically to support in a healthcare setting. On average, this can consist of at least 1600 hours of extra training (Frank, 2017). Consequently, chaplains are uniquely qualified to work in complex situations involving religion and spirituality that physicians might have difficulty navigating on their own. The AMA understands this; in their 2018 article from the *Journal of Ethics* relating to the role of religion and spirituality in healthcare, both physicians' and chaplains' duties are explained, showing that sometimes collaboration is the best solution to a religious and/or spiritual problem (Cook et al., 2018). While chaplains are a powerful resource available to physicians, as of 2017 only 60% of U.S. hospitals had a dedicated chaplain. Hospitals without this resource relied on volunteer support to fill this role (Frank, 2017). Without the ability to consistent rely on chaplains being viable resources, physicians might be called on more often to meet patient needs regarding religion and spirituality.

One final standard within the modern hospital that is designed to assist in religious competency returns to the idea of cultural competency. The U.S. Department of Health and Human Services Office of Minority Health designs and implements requirements of cultural

training known as national CLAS standards. Without providing an explicit model for cultural competency engagement, CLAS principles require hospitals and medical institutions to develop goals, training programs, leadership groups, and communication with local minority groups to increase training of employees to be more culturally aware. Cultivating understanding of other cultures is a step towards general religious competency as understanding other cultures entails physician understanding of viewpoints on tradition, community, and religious practice among their patients. The principal founding standard of CLAS, for example, is to "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health practices, preferred languages, health literacy, and other communication needs." (National CLAS Standards).

Chapter 4: Conclusions

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Summary of Findings and Results

As current trends show, religious and cultural diversity are likely to continue their upward trend over the next few decades. In addition, increasing attention is being paid towards the effects of religion and spirituality on patient wellbeing and recovery. As a cumulative result of all these factors, the hospital physician needs experience and training in religious and spiritual competency. Examining AMA guidelines prescribed for medical schools, it is apparent that efforts to promote and standardize religious and spiritual awareness have been made in the form of AMA policy. However, these policies provide a generous amount of flexibility and ambiguity that allow medical schools to independently control implementation of the material. Medical schools have also begun integrating religion and spirituality into training, examining different

course styles to optimize the impact of the material. A 2017 study deduced that at least 75% of all American medical schools have some form of instruction in religious and spiritual competency in their curriculum, such as George Washington University (Lewellen, 2016). However, based on the results of the study it seems that many medical students would prefer the course to remain optional. This indicates that religious and spiritual competency may still not be seriously considered an important facet of care. Hospitals are showing similar strides to incorporate cultural competency in curriculum, using spiritual assessment, chaplain resources, CLAS guidelines, and many other policies not discussed in this study. However, once again, the regulation of physician training in religious and spiritual competency is relatively ill-defined, shown in the vast quantity of possible spirituality assessments and broadness of American Medical Association standards.

Based on the research, one can safely assert that physicians are still not adequately prepared fulfill a role in patient religious and spiritual needs, despite visible efforts in the medical community to increase professional awareness of such issues.

Future Suggestions for Advancing Physician Training

While the current models may be deficient, they provide a foundation for researchers and thinkers to build on and eventually form a solid policy on patient religion and spirituality. In this section, some recommendations are made in conjunction with research and thoughts from professionals.

In medical school training, the need for standardized instruction in related religious and spiritual issues is necessary. While the AMA requiring cultural instruction is a commendable

step in the right direction, failure to designate how that material should be conveyed and utilized by medical schools creates room for inconsistent teaching from program to program.

Regarding suggestions for hospitals in general, professionals such as Marcelo Saad and Roberta de Medeiros have proposed broad steps to facilitate better accommodation of religious and spiritual needs. Saad and Medeiros first propose that a hospital connect its spiritual support department to other projects of the institution to ensure the department is financially supported (Saad & de Medeiros, 2016). As discussed previously, the spiritual support department is a useful tool for physicians and ensuring the stability of this resource will assist physicians in religious and spiritual encounters. More importantly linking the spiritual assistance department with other areas in the hospital could help integrate the pastoral care department into other departments. Consequently, physicians might interact with spiritual support more often and possibly become more confident in those issues. Step 2 outlined by Saad and Medeiros is a push to formalize training on religious and spiritual competency in staff training (Saad & de Medeiros, 2016). While training on these issues is likely the most direct way to fill gaps in physician knowledge, standardizing training across hospitals is difficult. Take, for example, the loose standards implemented by AMA regulation. A possible solution to this problem could be revising CLAS principles, the list of required cultural competency material covered by all medical schools, by including more detailed requirements such as a list of terms that must be covered in staff training. A third step outlined by the two authors is institutional dedication to supporting patient religious and spiritual needs. While the Joint Commission may require hospitals to create policies to promote equality, acceptance, and value in patient spirituality, Saad and Medeiros suggest hospitals more clearly convey this aspect of care to clients (Saad & de Medeiros, 2016). This may logically lead to more patients feeling comfortable expressing or

practicing their religion and spirituality around physicians, knowing they are in a safe place. Furthermore, implementation of this step is relatively simple. Many hospitals include a brief mission statement, values list, and vision detailing their dedication to patient care, improvement, and overall excellence. Considering Saad and Medeiro's suggestion, adding a "Religious and Spiritual Mission" would be a simple way to publicize this aspect of a hospital's dedication. The mission would need to factor in the diversity of religious and non-religious patients to prevent discrimination or favoritism, but ensuring that aspect of care might be reassuring for religious patients and provide another opportunity to connect with physicians.

While the present study has revealed some shortcomings in the American healthcare system regarding patient religion and spirituality, highlighted some new policies emerging to respond to these growing needs, and suggested further plans to progress the medical field in this area, the research conducted here was primarily exploratory. The hope is that this preliminary research has served to highlight an issue that can be ameliorated by future research and policy change. With improved training and policy, tomorrow's physicians will be better equipped to address the growing significance of religious and spiritual needs in patient care.

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