Spirituality, Healthcare and Medical Education: Views from New Zealand Medical Students

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A thesis submitted for the degree of Bachelor of Medical Science (with Honours)

At the University of Otago, Dunedin, New Zealand

January 2019
Abstract

Background

Spiritual care is becoming increasingly recognised as important for achieving better health outcomes as identified by patients, families of patients and healthcare professionals. However, spiritual care is not operationalised across the health continuum. Further, healthcare professionals have reservations about delivering spiritual care. To address the increasing demand for spiritual care, strategies worldwide are being implemented including spirituality courses in medical education. Until recently, spirituality has not had an explicit place in the curricula of New Zealand medical schools.

By investigating the perspectives of medical students, this project may provide a resource for the identification of knowledge gaps about spirituality in this population of Otago medical students which can be used to guide curriculum development. As these students represent some of New Zealand’s future medical practitioners, it is important to ensure that future training will produce doctors who are equipped to meet the increasing demand of spiritual care. Additionally, the majority of Otago medical students are young adults. Therefore, gaining an understanding towards their attitudes about the role of spirituality in their own health could serve as a stepping stone for integrating spiritual care in specialties where the health of young adults is a focus.

Methods

This project explored Otago medical students’ conceptual understandings of spirituality as well as its role in health, health care and medical education. I conducted interviews with 16 medical students located across all three Otago campuses (Dunedin, Wellington and Christchurch). Some students were at the start of their undergraduate medical training and others were in their final year. Transcripts from these interviews were analysed using thematic analysis.
Results

Among Otago medical students, spirituality is understood in a variety of ways. However, there is a general consensus that spirituality and religion are related but different constructs. Comparison between first and final year medical students showed no obvious differences regarding the level of understanding on spirituality as a concept. In terms of acknowledgement and receptivity towards spirituality, there were no marked differences between the year groups. However, final year medical students seemed to have a deeper appreciation of spirituality in healthcare, perhaps as a result of increased patient interaction and exposure to clinical settings.

Findings from this study suggest a gap in teaching on spirituality as relevant to patient health and healthcare delivery. Otago medical students heavily prefer an interactive platform for learning about spirituality. However, there are mixed views on whether or not spirituality learning should be compulsory or optional. Otago medical students have an inclination towards scientific and evidence-based topics. Development of a curriculum including spirituality should take this into account.

Findings from this study also showed a potential role of spirituality in stress management as it helped some students reframe situations in order to cognitively process them.
Acknowledgements

Working on this project has been an incredibly valuable journey and reaching the end of it is a testament to the immense support I have received from many people.

To the medical students who gave their time and self so generously to this project, thank you. I came away from each interview feeling deeply honoured for being let in to your lives and hearing about your personal stories. It felt refreshing to witness the level of willingness from each of you and I hope you are aware of how invaluable your contributions have been. I look forward to working alongside such kind-hearted people after we finish our medical training.

To my supervisors, Richard Egan and Hamish Wilson, thank you for your encouragement, understanding and guidance. Your support has been especially helpful in navigating this academic world that I am new in. It has been truly inspiring collaborating with advisors who are greatly passionate about their work.

I would like to acknowledge and thank the organisations who have financially supported this work, particularly The Selwyn Institute for Ageing and Spirituality for funding this project, and the Otago Medical School for the scholarship. You have allowed a young medical student to develop a deeper appreciation for research and its role in guiding clinical practice. Further, I would like to thank Fiona Hyland, from the Otago Medical School, for tirelessly helping me during the recruitment stage.

To my supportive and loving friends thank you for believing in me and continually checking up on me. To my flatmates, thank you for your reassuring presence the past year and especially for helping me get through those tough months. Also, I would like to thank my team at Student Health, especially my clinical psychologist. You embodied compassionate care and working with you has given me indispensable lessons.
To my family’s close friends and to my high school, St Peter’s College, thank you for your help especially with our immigration struggles. I would not have made it to university without your support. Then to Bishop Charles Drennan, thank you for your spiritual guidance and never-ending care for my family.

And finally, to my mom, Cecelia, my dad, Alan, and my sisters Marie Nance and Maria Cean, daghang salamat sa inyong mga sakripsiyo. I would not have been in this privileged position if it was not for your incredible efforts, resilience, and perpetual support and love.
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### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Tangata Whenua</td>
<td>local people, hosts, indigenous people i.e. people of the land</td>
</tr>
<tr>
<td>Te Taha Wairua</td>
<td>the spiritual dimension</td>
</tr>
<tr>
<td>Wairua</td>
<td>spirit</td>
</tr>
<tr>
<td>Wairuatanga</td>
<td>spirituality</td>
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</tbody>
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(Definitions from www.maoridictionary.co.nz)
# List of abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>EPE</td>
<td>Early Professional Experience (a programme within the Otago medical curriculum)</td>
</tr>
<tr>
<td>First</td>
<td>First-year Otago Medical Student</td>
</tr>
<tr>
<td>Final</td>
<td>Final-year Otago Medical Student</td>
</tr>
<tr>
<td>GP</td>
<td>General Practice</td>
</tr>
<tr>
<td>No</td>
<td>Self-identified as neither spiritual or religious</td>
</tr>
<tr>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Rel</td>
<td>Self-identified as religious</td>
</tr>
<tr>
<td>SC</td>
<td>Spiritual Care</td>
</tr>
<tr>
<td>Sp</td>
<td>Self-identified as “spiritual but not religious”</td>
</tr>
<tr>
<td>S/R</td>
<td>Refers to the overlapping concepts of spirituality and religion</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>US</td>
<td>United States</td>
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1 Literature Review

This literature review seeks to explore the conceptual understandings of spirituality and its role in healthcare and medical education. I begin the literature review with an examination of how spirituality is understood, including the arguments around conceptualising spirituality. Next, I consider the increasing recognition of spirituality internationally as well as in New Zealand. I subsequently explore the presence and role of spirituality in healthcare. Finally, I investigate the presence and role of spirituality in medical education.

The databases searched included Medline and Scopus, following advice from a subject librarian in the field of Health Sciences. Search terms included: spirituality, spiritual, health, medicine, medical, healthcare, medical students, medical school, medical training and medical curriculum. References were managed using the software Endnote X8. The reviewed literature is limited to those in English due to the capacity of the researcher. The time frame for searches began from the year 2000, as suggested by one of my supervisors, as spirituality and health literature was limited before this date.

1.1 How Spirituality Is Understood

There have been many attempts to conceptualise spirituality. Approaches include identifying common descriptors, generating definitions and distinguishing the different dimensions that construct it. Additionally, many critics argue that the broad nature of spirituality means that it overlaps with other constructs which makes measuring and thus researching it difficult. Despite this, the literature also recognises the importance of an inclusive understanding of spirituality, especially in the clinical setting.

1.1.1 Descriptors and Definitions

It is generally agreed that the concept of spirituality is broadly defined (Egan, MacLeod et al. 2011, Egan, MacLeod et al. 2014, Puchalski, Vitillo et al. 2014). Studies have also
identified common descriptors. People typically associate spirituality with a relationship to a higher power (Unruh, Versnel et al. 2002, Gall, Malette et al. 2011), beliefs (Egan, MacLeod et al. 2011, Stephenson and Berry 2015), meaning (Unruh, Versnel et al. 2002, Egan, MacLeod et al. 2011, Stephenson and Berry 2015, Weathers, McCarthy et al. 2016), purpose (Unruh, Versnel et al. 2002, Egan, MacLeod et al. 2011), transcendence (Unruh, Versnel et al. 2002, Berghuijs, Pieper et al. 2013, Stephenson and Berry 2015, Weathers, McCarthy et al. 2016) and connection (Gall, Malette et al. 2011, Weathers, McCarthy et al. 2016). A literature review of forty studies published between 2002 – 2012 found that connection to self, others, a higher power and nature were the four most supported descriptors in literature (Stephenson and Berry 2015).

Notably, it has been proposed that spirituality and religion can be overlapping constructs (Zinnbauer, Pargament et al. 1999). Thus, the term spiritual-religious (S/R) is often adopted to refer to these overlapping concepts (Saad, de Medeiros et al. 2017). Studies often showed that spirituality is viewed as more than just religious beliefs or affiliation (Egan, MacLeod et al. 2011, Weathers, McCarthy et al. 2016). In addition, some describe spirituality as a larger concept, wherein religion is a sub-concept (Sulmasy 1999, Swinton 2001). In other words, religion is just one of many expressions of spirituality. For example, in an article that reported on key words and phrases in the spirituality literature (Speck, Higginson et al. 2004), spirituality was defined as,

“the search for existential or ultimate meaning within a life experience…This belief usually refers to a power other than the self, which people may or may not describe as God, higher power, or forces within nature, and with which they communicate. The power helps the person to transcend the here and now, re-establish hope and the ability to cope”.

In the same article, religion was defined as “an expression of spiritual belief through a framework of rituals, codes, and practices; the sense of otherness or a power being a deity or supreme being”. The National Cancer Institute also defines religion as one way of expressing spirituality. Their definition of spirituality as “having to do with deep, often
religious, feelings and beliefs, including a person’s sense of peace, purpose, connection to others, and beliefs about the meaning of life” (National Cancer Institute). Sulmasy also describes religion as one way of expressing spirituality (Sulmasy 2002) while others express it through their relationships with nature, music, the arts, or a set of philosophical beliefs or relationships with friends and family.

Additionally, more and more people are starting to identify as “spiritual but not religious” (Astrow, Wexler et al. 2007, Koenig 2012), as exemplified in a United States (US) study where 60% of patients resonated with the label (Astrow, Wexler et al. 2007). This label further supports the position that spirituality and religion are related but different constructs, and that religion is part of the bigger frame that is spirituality.

It is important to note that spirituality and religion have not always been understood as different concepts. A book on the history of the spirituality reported that the term “spirituality” originated from Christianity and once referred solely to the connection with “God” (Sheldrake 2009). Today, some people agree that spirituality encompasses both religious and secular components. One definition, produced from an international conference where 40 national leaders, including physicians, nurses, psychologists, social workers, chaplains and clergy, other spiritual care providers, researchers, and health care administrators gathered to agree on recommendations for the field of spirituality and palliative care. The consensus-driven definition produced is:

**Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices (Puchalski, Vitillo et al. 2014).**

Noticeably, this definition contains many of the common descriptors reported at the start of this section. This definition is also only one of many definitions (Moberg 2002, Miller and Thoresen 2003) and is an attempt to address the lack of consistency in operational definitions within the field of spirituality and health (Steinhauser, Fitchett et al. 2017).
Part of the drive to establish the difference between spirituality and religion is to do with the shift away from the authority of religious institutions, as well as the growing trend of individualism, especially in Western societies (Steinhauser, Fitchett et al. 2017). Additionally, another force that propels the separation of spirituality and religion are the negative connotations around religion related to divisions, political views, war and indoctrination (Koenig 2012). For example, Pargament and Zinnbauer wrote about the trend that puts religion and spirituality in a dualistic framework. As they articulated,

The most egregious examples are those that place a substantive, static, institutional, objective, belief-based, “bad” religiousness in opposition to a functional, dynamic, personal, subjective, experience-based, “good” spirituality. (Paloutzian 2014)

However, not everyone thinks of spirituality in a positive lens. For example, in a Dutch study, 20.8% of the participants think of it in neutral or negative terms (Berghuijs, Pieper et al. 2013).

Later in the book, Pargament and Zinnbauer criticize this polarisation. When religion is depicted as static, it “does not address the way religion works and evolves in the life of an individual”, and when spirituality is identified as completely subjective, “it leaves the construct with weak boundaries”. However, others argue that the diversity in its conceptualisations among people does not make the concept of spirituality useless. For example, Swinton supports the idea that within spirituality, there are “identifiable components and experiences that can be understood, nurtured and cared for” which is what, he argues, the focus should be on (Swinton 2001).

Supporting Swinton’s position, Bregman, in an essay, urges people to focus on the more “useful task of mapping its current applications, and pondering why they have succeeded even as the term itself continues to be fuzzy, confusing, and yet widely appealing” (Bregman 2004). The essay concludes on discouraging more attempts to “provide a once-and-for-all-time definition of spirituality”. Similarly, Tanyi supports the notion of not providing “a definite overall definition of spirituality due to the subjective nature of the concept” (Tanyi
2002). Tanyi, through a conceptual analysis, instead focuses on clarifying what spirituality could entail:

- a personal search for meaning and purpose in life, which may or may not be related to religion.
- connection to self-chosen and or religious beliefs, values, and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace, and empowerment.
- the results are joy, forgiveness of oneself and others, awareness and acceptance of hardship and mortality, a heightened sense of physical and emotional well-being, and the ability to transcend beyond the infirmities of existence.

Apart from determining how it could be defined, another approach to conceptualising S/R is the identification of the dimensions that construct it. A Palliative Care Conference Report noted a lack of consistency in identifying these dimensions (Steinhauser, Fitchett et al. 2017). Salsman et al. addresses this need by demonstrating the four dimensions of spirituality: affective, behavioural, cognitive and other (Salsman, Fitchett et al. 2015). The taxonomy they developed illustrates the affective dimension as related to subjective emotional experience such as “a sense of transcendence, meaning, purpose, or connection to a source larger than oneself” as well as struggling with or feeling anger toward God (Salsman, Fitchett et al. 2015). The behavioural dimension refers to practices or behaviours to manage stress and life events such as meditation; prayer; pursuing a connection with God; attending religious services; and strengthening connections with religious persons, activities, or groups (Salsman, Fitchett et al. 2015). The cognitive dimension focuses on beliefs such as causal attributions, spiritual posttraumatic growth, religious fatalism, and intrinsic religious or spiritual beliefs (Salsman, Fitchett et al. 2015). The ‘other’ dimension includes measures that related to multiple dimensions or did not fit well into them like religious social support and religious affiliation (Salsman, Fitchett et al. 2015).
1.1.2 Clinical vs Research

Some have described the competing goals of defining spirituality for clinical and research contexts. In the clinical context, capturing the expansive nature of spirituality is beneficial for accommodating the plurality of beliefs and breadth of experiences among patients (Koenig 2012, Steinhauser, Fitchett et al. 2017). Whereas for research, discrete and measurable constructs are needed to produce non-conflating research (Berry 2005, Koenig 2012, Steinhauser, Fitchett et al. 2017).

Spirituality has been shown to have multiple descriptors, many of which overlap with other constructs. For example, Koenig points out that definitions which encompass purpose, meaning in life, connectedness with otherness, peacefulness, harmony and wellbeing are also describing positive psychological states. Koenig says that research that adopt similar definitions assures a positive correlation between spirituality and mental health because both constructs comprise of similar things, rendering findings meaningless (Koenig 2008). Koenig uses “tautology” to describe this which is the process of correlating something with itself (Koenig 2012). Salander supports this perspective in his brief review of spirituality research (Salander 2012). Therefore, some have debated that a narrower definition of spirituality is more preferable as it is more amenable to research (Puchalski, Vitillo et al. 2014). Additionally, the lack of consistency with definitions and taxonomy hinders independent studies from systematically informing one another (Steinhauser, Fitchett et al. 2017) because they use different conceptualisations and measures of spirituality.

In contrast, the pluralistic clinical setting calls for a broad definition of spirituality. Even though he recognises the need for discrete constructs, Koenig also acknowledges the assortment of beliefs and experiences that patients might have (Koenig 2008). In this setting, the language used should be broad and inclusive of the different aspects of spirituality found in various cultures and societies (Puchalski, Vitillo et al. 2014). In Koenig’s book on spirituality and health research, criteria for defining constructs in clinical practice are laid out. One of the points describes the goal of dialogue and engagement in a clinical setting which can be facilitated by a broad definition of spirituality (Koenig 2012). As articulated in his book, a definition that promotes conversation and focuses on similarities, not
differences, is valuable for clinical practice. Additionally, Berry suggests considering qualitative methods in research, which allow investigation of S/R as it is experienced by various individuals, which in turn can bring better understanding of S/R (Berry 2005).

1.2 Increasing Recognition

With the movement towards a more holistic approach to healthcare, spirituality and spiritual health have increasingly appeared internationally in health models, health guidelines, research and medical education. Spirituality is also being more recognised in the New Zealand context.

1.2.1 International

It is apparent that the topic of spirituality is gaining traction in the world of healthcare. This is exemplified by its inclusion in more recent models of health. To understand how this came about, it is important to consider previous models of healing and healthcare. One of the traditional models is the biomedical model (Engel 1977, Sulmasy 2002). The successes of medicine came about through this framework. It reduced the person to a specimen composed of biochemical and neurophysiological reactions and allowed the discovery of therapies that attend to these reactions when they are disturbed (Sulmasy 2002). Then, as proposed by George Engel, this model needed to be altered to broaden the approach to disease, thus giving rise to the biopsychosocial model (Engel 1977). Engel’s argument for this model included the need to take into account the patient, the social context in which they live, and the system developed by society to deal with the effects of illness to improve the way healthcare responds to patients. This model was then expanded by Sulmasy, who suggested a biopsychosocial-spiritual model (Sulmasy 2002). This model assumes that everyone is spiritual in the sense that all people have a relationship with the transcendent. The basis of this framework is that a human person is a being made up of relationships. Internally, there is the physical relationships of body parts, organs, physiological and biochemical process. Intrapersonal relationships also encompass mind-body relationships. The other relationships are external and these include the relationship with: the physical environment, other people and the transcendent. Sulmasy describes how illness disturbs more than just the relationships
inside the human organism and how holistic healthcare means attending to all of the disturbed relationships of the ill person, not just the internal ones (Sulmasy 2002). However, it is argued that the transcendent and sacred questionings of the spiritual dimension cannot be exhausted on the mental and social grounds (Saad, de Medeiros et al. 2017).

Health-related organisations worldwide have also been paying more attention to spirituality and health. For example, NHS Scotland published a guideline with key areas, skills and attitudes important for spiritual care (NHS Education for Scotland 2009). In the United States (US), The Joint Commission, a large accrediting body, requires health care organisations to address spiritual issues (Joint Commission). The National Coalition for Hospice and Palliative Care (NCHPC), an organisation that represents over 25,000 healthcare professionals in the US, has in their Clinical Practice Guidelines for Quality Palliative Care a whole section dedicated to Spiritual, Religious, and Existential Aspects of Care (National Coalition for Hospice and Palliative Care 2018). It contains guidelines on respect, spiritual assessment and treatment. The General Medical Council (GMC) which maintains the official register of medical practitioners within the United Kingdom (UK), has in their “Outcomes for Graduates” that doctors must be able to appreciate the links between the different factors for each individual, including spiritual factors (General Medical Council 2018).

Furthermore, the World Health Organisation (WHO) defines palliative care as

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organization)

The domain of research has also witnessed an increased interest in spirituality and health, with the US as the most productive country, followed by Australia and Canada, according to a bibliometric and scientometric analysis (Şenel and Demir 2018). A literature search with the keywords ‘spirituality and health’ noted a 600% increase in relevant articles between 1993 – 2002 and a 27% increase over the same time period was seen when the keywords
‘religion and health’ were used (Stefanek, McDonald et al. 2005). Aiming to analyse research in the field of S/R and health for the period 1999-2013 through a bibliometric analysis, a search using PubMed revealed that the number of publications are growing (Lucchetti and Lucchetti 2014). This analysis also showed that the US dominated the growth in publications, as well as the UK. India, Brazil, Israel, and Iran were also at higher positions in this list.

Spirituality and health have also been increasingly considered in medical education and curriculum development. However, this will be described later in this chapter.

1.2.2 New Zealand

As well as internationally, the topic of spirituality has been increasingly included in New Zealand (NZ) medical education, research and health care. Central to this inclusion in the NZ context are the commitments to the Treaty of Waitangi, NZ’s ageing population and its increasingly ethnically diverse society.

The Treaty of Waitangi is the founding document of New Zealand (Ministry for Culture and Heritage). It details the agreement between the British Crown and Māori or tangata whenua (the people of the land). Article the second guaranteed the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof unqualified exercise of their chieftainship over their lands, villages, and all their property and treasures (Ministry for Culture and Heritage). Across all of these areas, wairuatanga is fundamental (Egan, Cayley et al. 2013). For Māori, the term ‘wairuatanga’ is used to refer to the spiritual dimension and things related to the spirit (wairua) of an individual or living being (Egan, Cayley et al. 2013). Furthermore, values, beliefs and practices pertaining to wairua are considered a vital element of Māori health and wellbeing, as illustrated in the ubiquitous Māori health model called Te Whare Tapa Whā (Durie 1998). This model includes te taha wairua (spiritual aspects) as one of the four cornerstones of Māori health and is accepted by the NZ Government (King 2000). Additionally, the Māori population remain a big proportion of the NZ population, with 14.9% represented in the 2013 census (Statistics New Zealand Tatauranga Aotearoa).
New Zealand’s demography is changing in a direction where the importance of spiritual health is increasing, with growing plurality of ethnicity, age, spiritualties and cultures. With the aging population (Statistics New Zealand Tatauranga Aotearoa) spiritual care is becoming more relevant as spiritual issues arise with increased age (MacKinlay and Trevitt 2007). In an Australian study involving the baby boomer generation, spirituality was found to promote better health outcomes and lowers anxiety about ageing (Mackinlay and Burns 2017). In the same study, it was found that a group of participants, who reported lower levels of religious affiliation, reported higher levels of spirituality in comparison to another group with higher levels of religious affiliation (Mackinlay and Burns 2017). New Zealand is similar in the sense that even though religious affiliation is decreasing (Statistics New Zealand Tatauranga Aotearoa) the importance of spiritual care is still widely acknowledged (Egan, Llewellyn et al. 2017, Egan, MacLeod et al. 2017). In 2013, 41.9% of New Zealanders stated they had no religion, an increase from 34.6% in 2006 (Statistics New Zealand Tatauranga Aotearoa). This movement of spirituality and religious affiliation in different directions captures the change in understanding regarding spirituality, demonstrating that for many ‘spirituality’ is different to ‘religion’. Furthermore, New Zealand is becoming more ethnically diverse (Statistics New Zealand Tatauranga Aotearoa) which will add to the heterogeneity of the spiritual terrain in New Zealand.

Overall, the centrality of Māori perspectives, NZ’s ageing, increasingly secular and multi-ethnic society highlights the need for NZ healthcare professionals to develop competencies in the expanding complexity of holistic care. This need is beginning to be addressed by the rise of the presence of spirituality in research, health care and medical education1. For example, the Ministry of Health, which manages NZ’s health and disability system, included in its guidelines for supportive care for adults with cancer recommendations that address the

1 At the Dunedin School of Medicine, as part of their Early Professional Experience programme, students have taken a ‘spiritual history’ as part of their interview format with older people. In 2017, a one hour lecture on spirituality in medical care was also incorporated into the formal lecture schedule. Additionally, ‘spirituality’ is mentioned several times within the overarching guide to the curriculum called the Curriculum Map, but it is not clear how those particular learning objectives are translated into specific learning activities for students at various stages in their training, or how much these concepts are reinforced by clinicians and faculty during the clinical training phase of training.
spiritual dimension of patients and their family (Ministry of Health 2010). Since the year 2000, the Health Research Council has funded five projects incorporating spirituality (mainly related to Māori and Pacific issues) (Egan, Cayley et al. 2013). Additionally, research on NZ medical education (Lambie, Egan et al. 2014), medical students (Krägeloh, Henning et al. 2015), hospice care (Egan, MacLeod et al. 2011, Egan, MacLeod et al. 2017), renal care (Egan, Macleod et al. 2014), general practice (GP) (Holmes 2010), oncology (Knitter 2011, Egan, McKechnie et al. 2013), nurses (Egan, Llewellyn et al. 2017) and other healthcare staff (Shah, Frey et al. 2018) have also been carried out. In 2010, a total of 239 published papers, books, chapters, theses and conference presentations on spirituality authored by New Zealanders were identified (Egan, Cayley et al. 2013).

1.3 Spirituality and Healthcare

There is evidence to support and factors to consider with the integration of spirituality into healthcare. This integration has sometimes been called spiritual care (SC), defined as,

“recognizing and responding to the multifaceted expressions of spirituality we encounter in our patients and their families. It involves compassion, presence, listening and the encouragement of realistic hope, and might not necessarily include any discussion of God or religion” (Anandarajah and Hight 2001).

“Indirect” spiritual care has also been described in the literature and is characterised by active listening and being present (Vermandere, De Lepeleire et al. 2011). Perceptions on S/R as relevant to healthcare have been explored from the viewpoint of patients, families as well as healthcare professionals. The association between S/R and health-related constructs have also been investigated. Despite its benefits and people’s receptivity towards it, SC is still somewhat lacking. There are many studies that explore how SC should be implemented. Additionally, it is important to consider the multiple barriers to carrying out SC.
1.3.1 Perceptions and Associations

It is reported that patients (Astrow, Wexler et al. 2007) and their family (Slape 2014, Kiyancicek and Caydam 2017) have spiritual needs, which is acknowledged by healthcare professionals (Egan, MacLeod et al. 2014). A UK study revealed that medical students and faculty indicated that personal faith or spirituality is important to some patients (Harbinson and Bell 2015). Multiple studies have shown that patients think it is appropriate for physicians to address their spirituality (Astrow, Wexler et al. 2007, Vallurupalli, Lauderdale et al. 2012, Balboni, Sullivan et al. 2013) or at least be aware of it (Taylor, Mulekar et al. 2011, Best, Butow et al. 2015). Most physicians are also receptive to the inclusion of spirituality into healthcare (McCord, Gilchrist et al. 2004, Saguil, Fitzpatrick et al. 2011, Kattan and Talwar 2013, McGovern, McMahon et al. 2017, Gattari, Arfken et al. 2018). However, it is important to note that not everyone agrees with this. For example, in a study with primary care residents, less than half of the respondents felt they should play a role in patients’ lives related to S/R (Luckhaupt, Yi et al. 2005). Similarly, UK medical students and faculty supported the inclusion of the physical, social and psychological components of care but were less convinced with SC despite acknowledging the potential importance of S/R (Harbinson and Bell 2015). Furthermore, there seems to be certain factors that are associated with being receptive or unreceptive to SC. Among physicians, training and personal S/R levels affect perceptions toward SC (Luckhaupt, Yi et al. 2005, Grossoehme, Ragsdale et al. 2007, Saguil, Fitzpatrick et al. 2011, Balboni, Sullivan et al. 2014, Best, Butow et al. 2016). A US study showed that parents who self-identified as moderately or very spiritual or religious were most likely to be receptive to S/R discussions (Arutyunyan, Odetola et al. 2018). In a study with advanced cancer patients, receiving prior SC, increasing education and religious coping were related to favourable attitudes towards SC (Phelps, Lauderdale et al. 2012).

In addition to the perceived importance of S/R, studies have also shown the potential relationship it has with health (Powell, Shahabi et al. 2003), health behaviours (Hook, Worthington et al. 2014), quality of life (QoL), positive emotions (Vaillant 2008) and coping. For example, S/R and its relation with coping has been suggested by doctors (Gattari,
Arfken et al. 2018), medical students and staff (Harbinson and Bell 2015), family (Pierce, Steiner et al. 2008, Hawthorne, Youngblut et al. 2016) and patients (Vallurupalli, Lauderdale et al. 2012). Wachholtz et al. wrote about S/R coping, defined as a multidimensional variable that comprises a variety of S/R strategies that may serve to assist individuals with stressors they are confronted with (Wachholtz, Pearce et al. 2007). These include practices like prayer and seeking spiritual support. In their article focused on S/R and pain, Wachholtz et al. also described how S/R coping does not necessarily change pain severity, but rather changes pain tolerance. They proposed that this allows patients to continue with their daily activities despite increased pain levels. Higher pain tolerance as an effect of positive spiritual coping strategies is also described in the review article by Siddall et al. (Siddall, Lovell et al. 2015). Additionally, investigations have showed a relationship with S/R and both patient QoL (Adegbola 2011) and caregiver QoL (Adegbola 2011, Delgado-Guay, Parsons et al. 2013). Furthermore, the existence of an association between health and S/R has been acknowledged by medical students and staff (Powell, Shahabi et al. 2003, Lambie, Egan et al. 2014, Harbinson and Bell 2015), doctors (Kattan and Talwar 2013, Gattari, Arfken et al. 2018), and patients (Ellis and Campbell 2004). In terms of its association with health behaviours, Davies et al. wrote about how S/R has been shown to be related to how an individual takes care of their body and substance abuse patterns (Davis, Worthington et al. 2014).

Negative aspects of S/R have also been described in the literature. For example, Pargament et al. wrote about S/R struggles which may take different forms and is usually a result of “an encounter between an individual and a situation that endangers or harms the ultimate spiritual destination, be it the promised land, self-realisation, or union with God” (Pargament, Murray-Swank et al. 2005). They also contend that S/R struggles can “lead to despair, hopelessness, and meaninglessness on the one hand, and renewal, growth, and transformation on the other”. Other studies have also reported on negative S/R coping, described as maladaptive types of S/R coping (Wachholtz, Pearce et al. 2007). Wachholtz et al. spoke of two subtypes of negative S/R coping: patients feeling punished by God, and patients feeling abandoned by God. A longitudinal study on religious struggle found that negative S/R coping was related to poorer physical and mental health outcomes (Pargament, Koenig et al. 2001).
Salsman et al. conducted a series of meta-analyses, in the field of cancer, that considered the relationship between health and different dimensions within S/R, defined as affective, cognitive, behavioural and other dimension (Jim, Pustejovsky et al. 2015, Salsman, Pustejovsky et al. 2015, Sherman, Merluzzi et al. 2015). In the meta-analysis that focused on physical health, it was found that greater S/R is associated with better patient-reported physical health (Jim, Pustejovsky et al. 2015). Furthermore, the authors determined three subcategories of physical health:

- Physical health was defined a priori as physical well-being (ie, an ability to perform activities of daily living ranging from basic self-care to more strenuous physical activities), functional well-being (ie, perceived difficulties in fulfilling roles at home, at work, or in the community due to physical health), and self-reported physical symptoms (ie, fatigue, pain, sleep, cognition, and other physical symptoms).

It was found that affective S/R was associated with all subcategories of physical health. Cognitive S/R was linked to physical and functional wellbeing. Other S/R was related to functional wellbeing (Jim, Pustejovsky et al. 2015). The meta-analysis focused on mental health found a generally positive correlation between S/R and mental health, the strength of which varied as a function of the S/R dimensions and mental health domains assessed (Salsman, Pustejovsky et al. 2015). The final meta-analysis focused on social health and reported that all S/R dimensions were modestly associated with patients' capacity to maintain satisfying social roles and relationships in the context of cancer (Sherman, Merluzzi et al. 2015).

When it comes to S/R and its impact on healthcare, topics such as patient-provider relationship, medical costs, patient outcomes and decision making have been explored. In a US mixed methods study with oncology patients, physicians and nurses, qualitative analysis identified that SC would improve the patient-provider relationship (Phelps, Lauderdale et al. 2012). Surgical outpatients expressed that their trust would increase if their surgeon took a spiritual history (Phelps, Lauderdale et al. 2012). Similarly, a qualitative US study with hospice patients reported that patients may be more open to sharing aspects of their personal
lives that may contribute to better patient care if physicians are willing to inquire about patient S/R (Hart, Kohlwes et al. 2003). A survey with participants in different stages in their psychiatry training showed that 92.7% felt that consideration of patients’ S/R can improve treatment compliance and success (Gattari, Arfken et al. 2018). As reported in a study with patients and accompanying adults, the most important reason for discussing S/R was desire for physician-patient understanding (McCord, Gilchrist et al. 2004). Additionally, benefits for the healthcare system have been found when patient S/R is addressed. It has been shown that attending to the spiritual needs of patients with terminal illness is associated with greater hospice utilisation and less aggressive care (Balboni, Paulk et al. 2010) which results in lower medical costs (Balboni, Balboni et al. 2011). In terms of patient outcomes, unmet spiritual needs is associated with lower ratings of quality and satisfaction of care (Astrow, Wexler et al. 2007, Astrow, Wexler et al. 2007). An oncology study revealed that majority of patients, physicians and nurses believed that routine SC would have a positive impact on patients (Phelps, Lauderdale et al. 2012). This is supported by another study that showed that addressing spiritual needs is associated with higher QoL scores near death (Balboni, Paulk et al. 2010). With medical decision-making, it has been expressed that S/R plays a role (Jaul, Zabari et al. 2014). For example, in a study that explored parents’ views, the majority of participants stated that their beliefs influence the decision they made about their child’s medical care (Arutyunyan, Odetola et al. 2018). S/R has also been showed to be correlated with how patients make decisions (Ai, Park et al. 2008).

Even though much of the literature presented above points to the inclusion of S/R into healthcare, it is important to consider the limitations and in this field. For example, most studies are cross-sectional in design (Bonelli and Koenig 2013) which limits the possibility of drawing causal conclusions. This means that even though an association has been shown, it is difficult to determine whether S/R affects health or vice-versa or both. Berry, in an extensive report focussed on the methodological shortcomings in this field, suggested that studies often fail to measure or statistically control for health, behavioural, and demographic variables (Berry 2005). Berry also explains how some studies develop conclusions about S/R and health inappropriately as they use measures that are not designed to determine this relationship. It is also important to consider the sampling bias across the literature that is
Christian and Caucasian (Sinclair, Pereira et al. 2006), which limits generalisability. Limitations related to conceptual inconsistency have already been described earlier in this chapter.

1.3.2 Lack of spiritual care

The limited consideration of S/R within healthcare has been frequently reported. A 2015 systematic review of 54 studies described that physician–patient spiritual interactions are rare (Best, Butow et al. 2015). Qualitative findings from this review suggested that patients are often disappointed with the frequency of S/R discussions. Only 6% of patients reported that they were asked about their spiritual needs, as found by a US study on oncology patients (Astrow, Wexler et al. 2007). In a mixed-methods study with cancer patients and physicians, only 25% of patients reported previously receiving SC (Phelps, Lauderdale et al. 2012). A NZ study involving renal care units reported that formal spiritual assessments are not implemented (Egan, MacLeod et al. 2014). In a survey that explored the views of recently discharged patients, it was noted that more patients wanted a visit from a chaplain than received one while they were still in hospital (Piderman, Marek et al. 2010). Furthermore, family and caregivers S/R is not always addressed (Grossoehme, Ragsdale et al. 2007, Pierce, Steiner et al. 2008). Interestingly, a NZ study showed that even through explicit SC was rarely performed, ad hoc provision was carried out by some healthcare workers and family members (Egan, MacLeod et al. 2014).

Many barriers have been proposed to explain why the provision of SC is infrequent or absent. In terms of individual factors, discomfort (Ellis and Campbell 2004, Ellis and Campbell 2005), potential for offense (Ellis and Campbell 2004, Gattari, Arfken et al. 2018), lack of physician spiritual awareness (Ellis and Campbell 2005) and perceptions that S/R is too personal (Gattari, Arfken et al. 2018) have been reported. A study with renal physicians found that a lack in confidence, reluctance in initiating discussions, and lack in knowledge all impede the provision of SC (Egan, MacLeod et al. 2014). Concerns about proselytizing behaviour (Ellis and Campbell 2005, Gattari, Arfken et al. 2018), professional role conflicts (Ellis and Campbell 2004, Phelps, Lauderdale et al. 2012) and ethical considerations (Kattan and Talwar 2013) have also been suggested. Systemic barriers to SC include lack of: time
1.3.3 Components of Spiritual Care

When and how it should be provided, as well as whose role it falls under are factors that have been investigated in relation to spiritual care.

It is apparent that the degree (Arutyunyan, Odetola et al. 2018) and type (McGovern, McMahon et al. 2017) of illness has an influence on the desire for SC to be provided. For example, in a 2016 systematic review involving 61 papers, the authors found that the frequency of S/R discussion increases with terminal illness (Best, Butow et al. 2016). Similarly, a US survey revealed that parents’ desire for S/R inquiry from physicians increases if their child was seriously ill (Arutyunyan, Odetola et al. 2018). US primary care residents were more likely to agree with SC as the gravity of the patient’s condition increased (Luckhaupt, Yi et al. 2005). The most acceptable scenarios for spiritual discussion were life threatening illnesses (77%) and serious medical conditions (74%), as expressed by US patients and accompanying adults (McCord, Gilchrist et al. 2004). Additionally, psychiatry residents, regardless of cultural or religious background, consider S/R to be a factor in the treatment of suffering, depression, guilt, complicated grief, and addiction (McGovern, McMahon et al. 2017).

With regards to the nature of SC, there is uncertainty with how it should be approached. For example, there was an evenly distributed response stating it should be initiated by the patient, those disagreeing with that statement, and those who are not sure who should initiate the discussion, as revealed by a US study with psychiatry residents (McGovern, McMahon et al. 2017). Another study with patients reported a similar finding of there being varying views about who should initiate S/R discussions (Ellis and Campbell 2004). However, many studies have shown that physician characteristics are what matters, no matter how it is
initiated. In a qualitative interview with terminally or chronically ill patients, it was found that physician openness, non-judgemental nature and respectfulness may affect patients’ willingness to discuss S/R (Ellis and Campbell 2004). Similarly, a study with hospice patients reported that physicians were not expected to be spiritual experts, and that patients only expected physicians to respect their beliefs without preaching to them (Hart, Kohlwes et al. 2003). This is in line with a recognised component of SC, the patient-centred approach, which acknowledges that S/R can influence a patient’s understanding of their illness (Puchalski, McSherry et al. 2010). As suggested in its name, patient-centred care supports patients in their worldview, allowing them to set the agenda. A 2010 systematic review on spirituality and spiritual care at the end of life qualitative literature found that a patient-centred approach was advocated (Edwards, Pang et al. 2010). Additionally, focus group discussions with seriously ill patients revealed that physicians with strong interpersonal skills and a well-developed patient-physician relationship are important when it comes to S/R discussions (Hebert, Jenckes et al. 2001).

There is wide discussion about who should provide SC. It is uncertain whether this task should be delivered by doctors or left to others (Harbinson and Bell 2015). Hanzo and Koenig suggest that doctors should act as “SC generalists” and screen for S/R needs then if indicated, refer to chaplains, who can then “treat” S/R distress, as “SC specialists” (Handzo and Koenig 2004). Similarly, according to Saad et al. the role of the physician is to proactively identify S/R needs and trigger the available supportive resources accordingly (Saad, de Medeiros et al. 2017). In support of this, many physicians prefer chaplain referral over providing SC themselves, as reported by a 2016 systematic review involving 61 papers (Best, Butow et al. 2016). However, in a NZ study, healthcare professionals in hospices were open to doing either (Egan, MacLeod et al. 2014). As reported by a US survey, family members would also feel more comfortable having such discussions with a chaplain than with a physician (Arutyunyan, Odetola et al. 2018). This is likely to vary between countries given their different religion profiles.

What SC should involve has been extensively explored. One of the well-known ways of carrying out SC is using the HOPE Spiritual Assessment Tool, a systemic approach to
spiritual history taking (Anandarajah and Hight 2001). This tool helps with navigating S/R discussions by providing an outline of S/R topics:

- **H** - sources of hope, strength, comfort, meaning, peace, love and connection;
- **O** - the role of organized religion for the patient;
- **P** - personal spirituality and practices;
- **E** - effects on medical care and end-of-life decisions.

However, this tool has had minimal psychometric evaluation (Borneman, Ferrell et al. 2010). Another prominent tool is the FICA Tool (Puchalski and Romer 2000). It has been evaluated and findings suggest that it is feasible for clinical assessment of S/R, as reported by a US pilot study with cancer patients (Borneman, Ferrell et al. 2010). The tool covers the following:

- **F** – faith or beliefs i.e. What is your faith or belief? Do you consider yourself spiritual or religious? What things do you believe in that give you meaning to your life?
- **I** – importance or influence i.e. Is it important in your life? What influence does it have on how you take care of yourself? How have your beliefs influenced your behaviour during this illness? What role do your beliefs play in regaining your health?
- **C** – community i.e. Are you part of a spiritual or religious community? Is this of support to you and how? Is there a person or group of people you really love or who are really important to you?
- **A** – address i.e. How would you like me, your healthcare provider, to address these issues in your healthcare?
Furthermore, access to a chaplain, availability of counselling, and contact with a member of the patient’s own faith community were identified as important components of SC, as reported in a study with UK medical students and faculty (Harbinson and Bell 2015). Additionally, a US study with surgical outpatients showed that 63% of patients concurred that a spiritual history should be taken (Taylor, Mulekar et al. 2011).

1.4 Spirituality and Medical Education

This section contextualises spirituality in medical education. It includes spirituality’s current place in medical education, components of developing a curriculum around spirituality and spirituality’s role in the lives of medical students.

1.4.1 Place in Medical Education

Publications detailing the presence of S/R in medical curricula and in medical education research have increased, reflecting the increased recognition of S/R in the health field as mentioned earlier in the chapter. Lack of training on S/R and SC is commonly reported among physicians (Balboni, Sullivan et al. 2013, Kattan and Talwar 2013, Egan, MacLeod et al. 2014, Harbinson and Bell 2015, Kichenadasse, Sweet et al. 2017, Gattari, Arfken et al. 2018), but it appears that the presence of S/R in medical curricula is increasing. For example, in 1998 approximately 50 US medical schools offered courses on S/R (Puchalski and Larson 1998), and in 2012, this increased to over 100 medical schools (Lucchetti, Lucchetti et al. 2012). A 2012 bibliographical review reported on the character of S/R and medical education literature. The sample included 38 articles, of which 31 were from the US and 3 were from Canada (Lucchetti, Lucchetti et al. 2012). The same review also identified studies from Cuba, England, Germany and Iran. Since then studies have shown that S/R is present in some medical school curricula in Brazil (Lucchetti, Lucchetti et al. 2012), Australia (Bennett, Bridge et al. 2014), and New Zealand (Lambie, Egan et al. 2014). Where spirituality has been incorporated into medical curriculum, teaching on the following content has been reported in both undergraduate and in postgraduate programmes: spiritual history taking, chaplaincy, spiritual needs, spirituality at the end of life, spiritual distress and S/R assessment (Lucchetti, Lucchetti et al. 2012). Additionally, investigations on how S/R should be
included in medical curricula have been done in South Africa (van Rensburg, Szabo et al. 2013), Iran (Memaryan, Rassouli et al. 2015), and the UK (Harbinson and Bell 2015).

Recommendations on learning objectives around spirituality and healthcare have been proposed (Lucchetti, Lucchetti et al. 2012). These include: all students should be able to take a spiritual history as part of the medical history; students should have an understanding of the role of S/R in patient care in many different clinical scenarios; students should understand that their own spirituality is a way to provide compassionate care; and students should understand that the care of patients involves the spiritual in addition to the biopsychosocial aspects of patients’ lives.

Difficulties regarding teaching spirituality have been expressed (Lucchetti, Lucchetti et al. 2012, Lambie, Egan et al. 2014, Egan, Llewellyn et al. 2017) which could partly explain the lack of its inclusion in medical education. Some curriculum developers attribute this partly to the broadness of the field (Lambie, Egan et al. 2014).

1.4.2 Developing a Curriculum

Multiple studies have investigated the effects of implementing SC training. Psychiatry residents who took part in a 3-year curriculum on S/R endorsed the course as a worthwhile experience, finding it helpful and meaningful (McGovern, McMahon et al. 2017). SC training has also been shown to improve competency (Awaad, Ali et al. 2015, Anandarajah, Roseman et al. 2016, Geer, Visser et al. 2017, van de Geer, Veeger et al. 2018). Increased awareness of the relationship between S/R and mental health was found in a Canadian study with psychiatry residents (Kattan and Talwar 2013). Increased awareness of chaplaincy services was also reported in a Dutch study where chaplains acted as trainers to hospital staff (Geer, Visser et al. 2017). In a longitudinal study comparing physicians who received SC training with those who did not found that ten years later, doctors who did not receive SC training had more struggles with SC (Anandarajah, Roseman et al. 2016). Additionally, changes to physician attitudes regarding S/R was a common outcome of SC training. Lowering of perceived barriers (Geer, Visser et al. 2017), increased comfort around the topic (Kattan and Talwar 2013) and increased appreciation of S/R in the holistic care of patients
(McGovern, McMahon et al. 2017) were some of the attitude changes experienced by doctors following SC training. Importantly, there are limited investigations on how SC training for doctors affects patient outcomes. A palliative care study showed improvements in patient QoL after staff received SC training (Yang, Tan et al. 2017). However, there was no effect on patient spiritual wellbeing.

Education on S/R topics is favoured (Kattan and Talwar 2013, Harbinson and Bell 2015, McGovern, McMahon et al. 2017) and acknowledged as important (Memaryan, Rassouli et al. 2015, Gattari, Arfken et al. 2018), but careful consideration of the different factors related to curriculum development is needed (Memaryan, Rassouli et al. 2015). For example, a Harvard study suggested that both curriculum format and content should be regarded when planning a S/R course (Mitchell, Epstein-Peterson et al. 2016). In terms of format, longitudinal (Mitchell, Epstein-Peterson et al. 2016) and experiential or process-oriented (Awaad, Ali et al. 2015, Mitchell, Epstein-Peterson et al. 2016) learning has been recommended. There are mixed opinions on whether it should be voluntary or compulsory (Harbinson and Bell 2015, Mitchell, Epstein-Peterson et al. 2016). Small group teaching was the favoured delivery method as reported in a UK study (Harbinson and Bell 2015). Similarly, a US study showed that students had positive feedback about small-group discussions, and that students notably expressed interest in learning through patients’ personal stories and through physicians’ personal experiences with spiritual issues in patient care (Tang, White et al. 2002). In terms of content, there is wide discussion on what should be included. Some feel that only basic knowledge of major world religions and patient spirituality is necessary, as found in a UK study (Harbinson and Bell 2015). In the same study, other participants endorsed learning on: the influence of S/R on patient attitudes and health-related behaviours; and S/R and disease. Another study, conducted in the US, suggests a full S/R curriculum encompassing: personal S/R growth; integration of S/R values into professional identity; addressing patient S/R needs; S/R and institutional dynamics; and controversial social issues commonly related to S/R ie. abortion (Mitchell, Epstein-Peterson et al. 2016). How SC fits in a multidisciplinary team has also been recommended to be included in S/R education (Geer, Visser et al. 2017). US psychiatry residents were interested acquiring knowledge that would assist them in their daily care of patients, as well as learn
about different S/R beliefs and their impact on mental health (Kattan and Talwar 2013). They also wanted to develop skills in taking a spiritual history. This is supported by other investigations that show desire for learning how S/R affects patient management (Harbinson and Bell 2015, Memaryan, Rassouli et al. 2015, McGovern, McMahon et al. 2017), like making referrals to spiritual experts.

As well as curriculum format and content, some of the literature has suggested considering external factors for developing S/R courses. For example, an Iranian study noted that culture and S/R belief in a community can act as a facilitator or inhibitor in the integration of S/R in medical curricula (Memaryan, Rassouli et al. 2015). Likewise, a study that included three countries found that attitudes towards S/R and health varied significantly between the countries (Lucchetti, Ramakrishnan et al. 2016). Therefore, ethnicity and culture must be taken into account when it comes to developing curricula with S/R.

1.4.3 Spirituality and Medical Students

It seems that there is a relationship between medical student’s S/R beliefs and medical school experience. As reported in some studies, levels of S/R among medical students change as they progress through medical school (Balboni, Bandini et al. 2015, Harbinson and Bell 2015). S/R could also have an impact on how medical students are socialised as suggested by a US qualitative investigation (Balboni, Bandini et al. 2015). In this study, Balboni et al. describe the hidden curriculum (HC) which is a process of formation which results in medical students internalising certain behaviours and attitudes. However, some of these behaviours and attitudes are toxic. Such toxicity includes the dehumanisation of patients and prioritising efficiency, which affect patients and doctors negatively. Medical students becoming less sensitive, less involved, less available, less comprehensive, and less humanised as they graduate has been described in Cuban literature (Lucchetti, Lucchetti et al. 2012). As revealed in their interviews, S/R seems to protect some medical students from this negative socialisation (Balboni, Bandini et al. 2015). Furthermore, the progression through medical school seems to have a relationship with how medical students view S/R and health, as reported by a UK study (Harbinson and Bell 2015). The findings showed that
Younger medical students tended to recognise the relationship between S/R and physical health more.

The link between medical student S/R and coping has also been explored. For example, a US qualitative study showed that student S/R influences coping strategies during encounters with patient suffering. The findings demonstrated that spiritual or religious students tend to adopt prayer, faith, and compassion as key means of coping. Whereas in non-spiritual or non-religious students, compartmentalisation and emotional repression were discussed as a way of responding to patient suffering (Balboni, Bandini et al. 2015). Similarly, another US qualitative study found that S/R helps students cope with the stress of medical school (Ray and Wyatt 2018). The same study also showed that S/R helps students make clinical decisions, resolve inexplicable events, and practice patient-centred care. Furthermore, a NZ quantitative study reported that no matter the basis of medical students’ existential beliefs, benefits from these beliefs appear to be provided by giving the student a sense of purpose and meaning, as well as hope and optimism for the future (Krageloh, Henning et al. 2015). This finding was consistent for students whose S/R was based on a formal religious faith, whether beliefs were more informal and spiritual, or whether beliefs were based on a personal and general philosophy of life.

1.5 Summary

This review explored how spirituality is defined and understood, as well as the place spirituality has in healthcare and medical education. While there is general consensus around the potential importance of spirituality in patient health, there are multiple challenges that impede on the integration of spirituality into healthcare. To address these challenges, the literature has called for a clearer idea of what spirituality encompasses, as well as more effort in developing spirituality training for healthcare professionals. By interviewing medical students on how they understand spirituality and its relationship to healthcare, as well as its place in their own medical training, this project aims to meet the aforementioned recommendations for future research.
2 Methodology

This chapter covers my ontological and epistemological position. I have also described my personal background to help the reader analyse the study critically, given the impact the researcher has on the research in qualitative studies.

I resonate with the constructivist paradigm (Denzin and Lincoln 2018) which acknowledges that realities are self-created and based on the individual’s lived experiences, which results in multiple realities. Patton similarly conveys the same view and explains constructivism as a result of the ability of humans to interpret and construct reality (Patton 2002). Additionally, constructivists study the multiple realities created by people and the implications those constructions have on a person’s life and those who interact with them (Patton 2002), an approach that I agree with. In terms of epistemology, the constructivist paradigm recognises that findings are due to the interaction between the researcher and the participants. This means that the researcher’s lived experiences will influence the knowledge they generate about the subject’s reality (Denzin and Lincoln 2018). Typically, as such in this project, qualitative methods are used in research that subscribes to the constructivist paradigm (Denzin and Lincoln 2018). Furthermore, a qualitative research method was employed due to its ability to facilitate study of issues in depth and detail (Patton 2002).

Kuper et al. recommend qualitative researchers “situate” themselves through identifying their own context and that this should be made explicit in qualitative reports to help the reader determine for themselves what effect the researcher’s background has on the findings of the study (Kuper, Reeves et al. 2008). With this in mind, I have situated myself below.

I come from a middle-class Filipino background. I lived in an urban area in the Philippines until I was 10, after which I moved to New Zealand with my family. I have two older sisters; one is a nurse and the other is a nursing student. My mother was a nurse in the Philippines and following struggles with gaining recertification in New Zealand, worked as a caregiver for many years and now works as a support worker for people with intellectual disabilities. My father inspected furniture in the Philippines and became a dairy farmer once he moved
to New Zealand. He is now jobless as his current health status does not allow him to work. Overall, the past decade of my life has been characterized with immigration struggles but has been made manageable and enjoyable by multiple kind and generous people.

I have always been interested in spirituality; I was raised in a Catholic family and attended Catholic school up until university. I have been heavily involved in the Catholic community - volunteering in church services and leading and attending Catholic camps and youth groups. My involvement in this community has decreased significantly following a big change in my beliefs around faith and spirituality which happened during the early stages of this project. However, I remain connected to it. The transition from my Catholic-centred life to a more secular way of living was a trying time and it affected the interview process in this study. As detailed in the limitations section later, my interviews were weighted more towards medical students’ spiritual journey which is likely to be a reflection of my heightened interest in my own spiritual journey at that specific period.

As a medical student and growing up with my mother being a nurse, I have always been interested in health. After my rest home placement in my first year of medical school, I became more interested in the intersection of my faith and medicine. The three-day rest home placement was not enough, and I felt that I had to immerse myself more in caring for people in that context to prepare me emotionally and to improve my skills for my future career. Therefore, the following summer I took up a caregiving job. It was during this time where it was made obvious to me the centrality of spirituality in holistic care, especially in the rest home setting. I had conversations with residents about their spirituality and it was apparent that some residents did not have their spiritual needs met. A lecture on spirituality and medicine, delivered by one of my supervisors, the following year fostered even more interest. That same year, some of my close friends were going through tough health issues and it made me wonder how they coped with it. It made me think about the role of spirituality in the health of young adults. This combined with a similar curiosity as to how my parents have overcome all of their life struggles, as well as a long-held interest in spirituality and health, made me embark on this research project. Additionally, it was apparent to me, following
conversations with fellow medical students, that the concept of spirituality is still unclear among our population. This also provided impetus for this study.
3 Methods

Qualitative methods were chosen for this project as it best suited the exploratory nature of the research (Patton 2002). Face-to-face and video chat semi-structured interviews were conducted with medical students from the Dunedin School of Medicine. Interviews were thematically analysed: audio recorded, transcribed, coded, and themes emerged. The project was approved by the University of Otago Human Ethics Committee (Appendix A, ref F18/005). Māori consultation was carried out via the University of Otago’s Ngāi Tahu Research Consultation Committee process (Appendix B). The Otago Medical School (OMS) reviews requests to contact undergraduate medical students to participate in research into aspects of their education. This is to ensure students are not going to be overloaded or involved in research considered inappropriate or of poor quality. An application was made to and approved by OMS regarding this study (Appendix C).

3.1 Participant Recruitment

Participants were selected from a random sample of 2nd-year and 6th-year medical students using random sampling. Otago Medical School does not release a list of their students. Therefore, random selection and email distribution was done by an Otago Medical School administrator on the primary investigator’s behalf. Please see Appendix D for a letter to confirm this.

150\(^2\) randomly selected students from each cohort were invited to take part by email and a further reminder email to non-responders was sent. They were asked to complete an online Response Form which recorded their response (interested/not interested). We planned to look at the composition (age, ethnicity etc.) of the potential participants if we had more than 10 willing participants per cohort and select people to achieve a maximum variation sample.

\(^2\) To ensure that there would be enough interested respondents, 150 students were randomly selected following advice from the OMS administrator. The OMS administrator suggested this number was appropriate because of their recent experience with receiving low response rates from the current cohort.
Maximum variation sampling aims to maximise “the utility of information from small samples” where participants are selected based on expectations about their information content (Denzin and Lincoln 2011). As there is considerable heterogeneity among Otago medical students, this approach ensured that different and/or shared views regarding spirituality and its role in healthcare among the students with different backgrounds are explored. The email (Appendix E) included:

- Link to a Response Form that also asked about the student’s details ie. Name, Student ID, gender, date of birth, citizenship, ethnicity, religion, and entry pathway. Ethnicity data was collected using the question format used in the Census. For non-interested students, they were also asked to provide a brief explanation about why they did not want to participate. This was done through the RedCap web application. Please see Appendix F for what this online form contained.
- The Otago Medical School administrator, Fiona Hyland, advised us a file attachment would not be possible. Therefore, the Information Sheet was in the body of the email.

For interested students, by completing the online form, they affirmed they had read and understood the Information Sheet and therefore consented to participate in this project. For this reason, we did not include a Consent Form. We made it clear in the Information Sheet, the Recruitment Email and the online Response Form that informed consent was going to be obtained in this way.

Semi-structured interviews, either face-to-face or through Appear.in, with Otago medical students across all three campuses (Dunedin, Wellington and Christchurch) were conducted.

3.2 Development of the Interview Protocol

The interview schedule was informed by a preliminary literature review and the research objectives. It was focused on the following domains: spirituality as a concept, spirituality and health in patients, spirituality and health in medical students, spirituality in healthcare and spirituality in medical education.
A semi-structured approach was suggested by my supervisors as it would allow me to both explore ideas related to my research objectives in depth but also follow up on cues presented by the participant so that the interview was able to adapt accordingly (Patton 2002). Patton describes the advantage of an interview guide as allowing the interviewer to decide how to best use the limited time available (Patton 2002).

Before finalizing the interview schedule, I conducted three face-to-face pilot interviews with medical students, as suggested by my supervisors, to check the acceptability, timing and appropriateness of the interview schedule as well as to prepare myself as I had not conducted research interviews before. See Appendix G for the Interview Schedule.

3.3 Data collection

Data collection involved semi-structured, face-to-face and video chat interviews between August-September 2018. It took place in private rooms in the library and in the research department. The interview was preceded by informal conversation to build rapport and allow the participants to feel comfortable. Following this, the participants were given an overview of the schedule and their rights as research participants. The interviews followed the interview schedule and deviated from it occasionally depending on the cues from the participants. The audio of the interview was recorded. Once the interview had finished, the investigator asked the participants if they had questions for the investigator or anything else to add, then presented the vouchers, thanking the participants for their involvement. The participants were then escorted out as more informal conversation took place.

In my original research proposal, I sought to conduct 20 interviews, with advice from my supervisors, to reach saturation. Saturation is the stage in data collection at which nothing new is being learned from the participants (Patton 2015). However, restricted time frames resulted in 16 interviews in total.
3.4 Analysis

After each interview, I wrote about my general feelings during the interview, and how I thought I performed, as well as any initial ideas or themes that were raised during the interview. I employed a transcription agency to transcribe the audio recordings. Analysis of the transcription came in the form of thematic analysis, a process that was informed by Braun and Clarke’s step-by-step guide (Braun and Clarke 2006).

As the transcriptions came back, I listened to the audio while simultaneously reading the document to check for inconsistencies, allowing myself to be immersed in the data. Time constraints meant that I could only do this twice for each interview. During this process, I assigned codes, took notes of reflections and insights. Initially, I considered using the NVivo software for coding, however, time constraints meant that I was not able to be trained in using the software. Instead, I used Microsoft Word as the platform for my coding, making use of the highlighting and commenting features.

Once I coded all of the transcripts, I reviewed them and organized the codes into potential themes (Braun and Clarke 2006). This was a lengthy process and involved going back and forth to transcripts and audio recordings. I used mind maps to visualise the developing themes. Analysis involved both deductive and inductive approaches; deductive being analysing data according to an existing framework, determined by a preliminary literature review, and inductive involving discovering patterns in the data itself (Patton 2002). I consulted with my supervisors about the themes and frameworks that were being developed.

Following analysis was the write up of the results chapter. It is important to note that further analysis occurred in the writing stage and involved going back and forth to my themes and mind map. In the write up, pseudonyms were used to protect the identity of the participants.
4 Results

The following chapter reports recruitment results, participant demographics, and thematic results. Pseudonyms have been used to protect the identity of the participants.

4.1 Recruitment Results

150 invitation emails were sent to both first-year students and final-year students. Of the 300 emails sent, 89 students responded. Of these, 34 first-year students and 28 final-year students were interested in the study. The remaining 27 students were not interested to participate. Those who did not want to be interviewed gave a range of reasons, including: being busy; not being self-aware on their own stand on spirituality; fear of distressing experiences being brought up; no interest; or felt discomfort around the topic. See Appendix H for a summary table about those not interested that includes their self-identified label of either religious, spiritual but not religious, or neither.

4.2 Participant Demographics

Of the 16 people interviewed, there were eight men and eight women. There were four participants in the under 20 year-old age bracket, eleven participants in the 20-30 year-old age bracket and one participant in the over 30 year-old age bracket. Seven participants self-identified as NZ European. Five participants self-identified as Māori. Two participants self-identified as Chinese. One student self-identified as Malay and one student self-identified as British European. Seven participants self-identified as “spiritual but not religious”. Three participants identified as “religious” and six participants identified as “neither” spiritual or religious. Ten students entered medicine through the Undergraduate pathway. Four students entered through the Graduate pathway and two students entered via the Alternative pathway. See Appendix I for a table of the participant demographics.
4.3 Themes

The section describes the themes that emerged: Understandings of Spirituality, Spirituality and Healthcare, Spirituality and Medical Students, Spirituality and Medical School Experience, and First Year vs Final Year Medical Students. An additional theme, Training Preferences, which was not part of the original research questions, is also included.

The following abbreviations have been made to indicate how participants self-identify:

- Re – Religious
- Sp – Spiritual but not religious
- No – Neither religious or spiritual

4.3.1 Understandings of Spirituality

All participants were asked about what ideas come up when they hear the word ‘spirituality’. This section begins to address the research question of what medical students understand about spirituality. Students articulated what they defined spirituality as. Additionally, they expressed their opinions on spirituality.

4.3.1.1 Definitions of Spirituality

In this group of medical students, spirituality was defined as something that: varies between individuals; is difficult to define; has a cognitive aspect; manifests in many ways; has an intangible component; provides hope, resilience and purpose; is related to religion. Another small set of responses was placed under the theme ‘outlier positions’.

There was a general consensus among medical students that spirituality is a broad concept that can be understood in a variety of ways:
Like there’s gonna be so much different stuff from different people and it’s just, I think it’s very like, a lot of people have different views on it (Iris, First, Sp)

My understanding of it is very broad and I think that it can range from a, include religion itself to just a, I guess an outlook on what life means and what it means to be a human. (Natalie, Final, Sp)

It is apparent that for many participants in both year groups, spirituality as a concept is difficult to define:

Not entirely sure…I couldn’t quite articulate it… Just I mean like that sort of like sets up a feeling within you that you can’t really describe (Henry, First, Sp)

I think it’s such an abstract and broad concept that it’s really hard to pin it down with words. (Ethan, Final, Sp)

Some participants used descriptors which imply that spirituality has a cognitive aspect that includes beliefs, a process of interpreting matters for a deeper meaning, and a process of understanding life or the world:

I guess is quite like a mental thing. Like it’s not behavioural” (Talia, First, No).

Maybe, if a person has faith in something... that counts as spirituality as well..., I mean, it’s a belief system. Like, you have faith in something, you believe in something... (Lucy, Final, Re)

I would say I am spiritual in that I constantly am thinking about meaning and trying to find meaning in things (Adam, Final, Sp)

In terms of what life means, our viewpoint in spirituality is how we approach our lives, how we approach our interactions with each other... so whether you believe that there is a deeper connection than just our face to face meetings, whether it involves a life force greater than ourselves or purely the life force within us, spirituality can also include, that we are simply organic beings that have a finite beginning and a finite end...and it doesn’t have to involve some life force or it doesn’t have to mean that there’s something greater than ourselves (Natalie, Final, Sp)

Natalie’s explanation of how a person’s understanding of what life means can affect how someone approaches life leads into another element of spirituality – how spirituality
manifests in people’s daily living. When participants described spirituality, some of them talked about the different ways in which it manifested in their own lives. For example, their relationship to nature, self-care, self-awareness and reflection were all tied to participants’ experiences of spirituality. Additionally, some medical students were aware of the potential variety of how spirituality can manifest for different people:

I guess, kind of can exist or manifest in whatever form and, and it’s completely unique to everyone... I have an appreciation of the natural world, and sometimes I meditate, and I get that spirituality, to someone else, might mean that they pray, or they starve during Ramadan, or, you know, they go to church. (Ethan, Final, Sp)

Many participants use descriptors such as. “beyond”, “higher power”, “force”, “connection”, and “relationship” which implies that there is an element of spirituality that is intangible:

A higher power, or in fate, or in karma, or in those, kind of, more abstract, kind of, things (Rose, Final, Re)

It’s more like a person’s understanding of things that we can’t see... yeah like different realms of things maybe... I guess like your understanding of relationships and relationship patterns, not just between people but also between I guess, the environment, this like relationship between other species like animals and stuff (Angel, First, Sp)

A number of medical students used what humans “physically experience” (Brett, Final, No) as a reference point and explained spirituality as a concept that is beyond what can be explained through “physical phenomenon” (Ethan, Final, Sp).

A number of students qualified their definitions of spirituality with positive descriptors. For example, one student said spirituality is about hope and purpose which helps “you move forward as a person” (Iris, First, Sp). Another student described spirituality as “what helps someone get through the good and the bad times” (Henry, First, Sp). Another student spoke of happiness as the end goal of spirituality:

I can come to a, like a spiritual belief without a religion, in a sense. But I think that it doesn’t matter if you have religion, but the end goal is still the same... like, people that are seeking that sense of purpose or that
reason, um, through their spirituality, to be happy, you know (Ethan, Final, Sp)

Religion

Religion was commonly used as a descriptor among the participants. The relationship between spirituality and religion was also described.

As participants defined spirituality, most of them started by mentioning its difference to religion. Rose makes the distinction between types of spirituality as she said “I guess I kinda split that into religious and non-religious” (Rose, Final, Re).

When asked what comes up in their head when they hear the word spirituality, for some participants, religion is the first idea that surfaces, as suggested in this quote “when people hear the spirituality, they automatically jump to like religion” (Iris, First, Sp). Similarly, Chase expressed, “I sort of straight away think religion.. Um, and, but I know that not everyone, like people have spirituality but not part of an organised religion” (Chase, First, Re). Harry recognised the semantic shift when he said “spirituality I think historically has sort of been, it’s a religious thing” (Harry, First, No).

Interestingly, for two religious students, they defined spirituality in exclusively religious terms, even though they recognised that people have spirituality outside of religion:

But to me, it like, you know I basically think of religion... Um, and just, thinking so there’s, like some sort of, spiritual being or like all powerful being or beings depending on... which religion you identify with or practice with. (Chase, First, Re)

I think, for me, it’s very much religion. (Lucy, Final, Re)

Many participants allude to the inherent spiritual nature within religion. Talia expressed that “religion implies a spirituality” (Talia, First, No). After expressing that religion and spirituality “can be very intertwined”, Brett described that “people that are religious…by almost default they’re quite spiritual, but there are also a number of people that are spiritual
without necessarily having a religion per say” (Brett, Final, No). Riley had a similar way of explaining it,

I feel as though like, you could be a religious person and a spiritual person. But you don’t necessarily have to be, a religious person if you are a spiritual person. But like people that are religious might also consider themselves to be spiritual. (Riley, First, Sp)

While articulating the relationship between spirituality and religion, participants often expressed that religion “gives a structure to spirituality” (Angel, First, Sp) and that “religion is an organisation of spirituality” (Troy, First, Sp). Iris argued that “religion is a way of entering those kinds of concepts but there are other ways as well” (Iris, First, Sp). Rose said that religion is a “framework for spirituality, and it’s a big set framework that lots of people around the world follow, and it has quite a set structure to it” (Rose, Final, Re)

**Outlier Positions**

There were some positions or comments regarding spirituality that did not fit into the labels above. For example, Henry said that “spirituality is the creative side to someone” (Henry, First, Sp)

Another outlier position was Harry’ definition. His view was that spirituality is a language that people use to describe elements of mental health:

I think it’s important as a health practitioner that we sort of go, well, spirituality is a language that other people use as well, so it’s important that we, even if they’re not religious, we talk about spirituality for them to make sure we’re not missing an opportunity to talk about something that they do for their mental health… ‘Cos for me, sort of meditating is looking after your mental health. But for other people it might be actually that’s a spiritual realm and so it’s important that we use the, the language that they want to use. (Harry, First, No)

4.3.1.2 Opinions on Spirituality

When participants were asked what ideas come up when they hear the word ‘spirituality’, many of them gave their opinions on spirituality, as well as religion. Participants talked about
spirituality being: a part of everyone; unusual; a personal or sensitive topic; a negative label. Positive and negative comments on religion were also expressed.

**Everyone is spiritual**

There was a common expression that “everyone has an element of spirituality” (Rose, Final, Re). Iris had a similar view that spirituality can be “a part of someone’s life whether they realise it or not” (Iris, First, Sp). Contrastingly, Troy does not think everyone is spiritual:

> I feel like, I don’t think everyone’s spiritual, but I feel like the majority of people are spiritual but, a, and a significant proportion are religions as well. (Troy, First, Sp)

**Dismissive/Unusual**

There was a set of comments from the participants that implied they were somewhat dismissive of the topic or at the very least, find the topic unusual. In Troy’s words, “this sounds so airy fairy. It’s like EPE all over again” (Troy, First, Sp). Similarly, Reece expressed, “it can be a wishy-washy sort of subject… it’s a bit like stoner talk” (Reece, First, Sp). Another example of this view is, “I dunno, we’re having a conversation about spirituality so it’s always gonna be cheesy” (Iris, First, Sp).

**Personal**

The opinion that spirituality is a sensitive topic was present among the participants, as exemplified by this student commenting on his experiences with having conversations on spirituality,

> I feel a lot of people are afraid as to the consequences of having that conversation. And they might put a foot wrong and offend someone (Troy, First, Sp)

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3 EPE (Early Professional Experience) is a programme that is part of the Otago medical curriculum.
Another student shares a similar opinion and said that it is personal. She said,

*I think it’s quite personal, as in, you know, when you talk about it you’re going, at the same time you’re actually touching on... some of the aspects of your personal lives* (Lucy, Final, Re)

**Label**

Among the three actively religious students, two expressed hesitation in identifying as ‘religious’:

*In my religious community, religion’s a bit of a negative word... To me, religion is, means discipline... it’s not religion, it’s relationship.* (Rose, Final, Re)

*Even if I was like fully Christian, I don’t think I would want to say I was religious* (Iris, First, Sp)

Iris also said it is “quite a common perspective even among Christians to say that they are spiritual but not religious” (Iris, First, Sp). She also explained a trend among Christians as to what label people are more comfortable with, as she expressed,

*I’d say at this end of the spectrum, at the Pentecost end of the spectrum, people are more inclined to say they’re spiritual rather than religious but people at the other end probably are more inclined to say religious.* (Iris, First, Sp)

The label ‘spiritual’ was off-putting for one student. He said, “I don’t necessarily always feel all that comfortable with that label and that stereotype of what spirituality is for want of a better word” (Brett, Final, No).

**Positive Comments on Religion**

Natalie, who previously identified as Protestant, acknowledged the positive outcomes of religion. In her words, “I appreciate the elements of religion that binds people and gives us a greater meaning to our individual lives” (Natalie, Final, Sp). Troy, who attended a religious high school found “the sermons interesting and very engaging…and the messages that they spread was great” (Troy, First, Sp).
Negative Comments on Religion

Negative views on religious elements were reasonably common, as exemplified by this student commenting on the restricted nature of religion, “religion has kind of like a stigma about being like in a straight line and you must do this, you must do that” (Iris, First, Sp). Riley indicates that “a lot of the major conflicts in our world have been because of clashes in different religious views” (Riley, First, Sp). Talia expresses another criticism, as she comments on religion being a “scam”:

> the people who, are high up within the church aren’t, you know don’t follow the, the bible really... I think. And, there’s a lot of money in it and I think... it was designed to control people. (Talia, First, No)

There was a set of responses that assessed certain religious views or practices. For example, two students criticised the concept of God:

> they [religions] are sort of all like, if you don’t believe in our flavour, you go to somewhere dark and nasty...which doesn’t resonate with an all loving, all powerful god” (Harry, First, No)

> And I feel as though if there is some sort of almighty being that you know loves us all equally and all that sort of side of things, then we would not be nearly as awful to each other. (Riley, First, Sp)

Harry also criticised the notion of assigning the responsibility of events happening on a God. He said that “it’s much better just to focus on, it’s happened, let’s deal with it and move forward” (Harry, First, No). Another critique on religious views, specifically on repenting for sins was expressed:

> You shouldn’t be like “Well, it doesn’t matter now because I went and repented,” or whatever they do. (Talia, First, No)

Brett held opinions on many religious teachings. He criticised religious views on women, sexuality, abortion and contraception and expressed that they are an “attempt to control women and their sexuality rather than any kind of genuine, you know faith in life or something like that”. Furthermore, he recalled teachers being a “sport of the creationist ilk” and he thought of them as “completely wilfully ignorant”. The church’s position on
homosexuality was something that Brett did not agree with. He shares an anecdote to illustrate his view,

*I had a friend... who have later come out as gay... and I remember a very religious student, um at our school who tried to take um one of my friends to um, you know, church for him to be healed of his homosexuality which is pretty, you know, I think abhorrent!*

4.3.1.3 Grappling of the Concept

This section reports on the apparent dynamic nature of medicals students’ understanding of the concept spirituality. It is apparent that many students have experienced changes in their own spirituality. Multiple sources of influence which affected their understanding were identified. Additionally, many participants allude to finding a position in terms of where they see themselves in their beliefs about spirituality. This journey of finding a position, for some, began after a pivotal moment, marking a turning point. For others, it was more of a gradual process. Overall, it seems that how students understand their own spirituality informs their broader understanding of the concept as a whole.

4.3.1.3.1 Journey of Understanding

It is apparent that some of the students delved deep into their own spirituality and reported changes in their beliefs throughout time. This was achieved through active exploration. Other sources of change included family, culture, school and friends. Overall, this section talks about students’ journeys with their own spirituality and factors which influenced their journey. Students’ answers were in response to being asked what their journey has been like in regard to their own spirituality.

Changes in Their Own Spirituality

Some students talked about being previously religious. Adam said, “I no longer believe in God at this time” but claimed that he can still “feel a connection to God regardless to whether or not he exists”. Natalie was also previously religious and considered herself “very much a Protestant Christian at that time” but in her late twenties, started to question:
The value of how much we put into an institution really for the running of the institution itself rather than... to better people or to help people through hard times in their lives or to give them something outside of themselves. (Natalie, Final, Sp)

Some participants also talked about becoming more accepting of spirituality:

I think I’ve probably become a bit more open to sort of spiritual beliefs and ideas um as I’ve sort of gone through my twenties. (Brett, Final, No)

[I have] shifted from that extreme, sort of, denouncing God, to being OK that, you know, people can believe what they want... and I think I’ve become more spiritual since then as well. So, yeah, like, I think my views about spirituality have evolved over time. (Ethan, Final, Sp)

Two of the religious students underwent changes in their religious spirituality:

[I have] slipped...a long way [from my religion]... [I am] Christian by title only... [I] never wanted to be like that. (Rose, Final, Re)

Lucy talked about how being born into her Muslim faith initially just meant doing what her parents instructed and “doing things out of routine”. It was not until she became older that this changed. Lucy said,

Until the age of, probably eighteen, I started to actually re-learn about my own religion (Lucy, Final, Re)

One student talked about cautiously exploring Christianity and implied content with not reaching an end point yet. In her words,

I still don’t really know because like I’m still exploring the whole Christian thing and I’m still not sure if that’s me yet or not... I think it’s a journey and I think that not everyone has finished on that journey or anywhere, you can be like any point in it and that’s like still ok. (Iris, First, Sp)

Active exploration

It is apparent that many participants underwent active exploration of spirituality, in varying degrees, through attending religious gatherings and personal research.
Three participants, as part of their active exploration, attended religious gatherings. Reece talked about going to Christian discussion groups to understand their ideas but he eventually stopped showing up because “they sort of double down and… they were never really going to change their mind to begin with”. Brenna also attended religious gatherings. She said she got involved in groups in medical school and in university. She said,

> *I went to a couple of like, there’s a medical student Christian group... or whatever at the University, the religious organisation... and I think another time I also went to like to this Q&A thing that they hosted just to see what they were gonna talk about...I learnt quite a lot... It’s a pretty important question I guess. (Brenna, Final, No)*

Harry was another student who attended religious gatherings, both formal services and discussion groups. For him, it was about keeping an open mind. Harry also drew conclusions about god from his active exploration. In his words,

> *I’ve gone to like youth groups or gone to churches or um, looked into Islam or you know... other um, looking into Sikh religion at the moment... Um, but again, you know just sort of always kept an open mind and looked into things...there’s lots of like little groups were you could like talk to a pastor about different things... essentially I’ve, I’ve come to the belief that I think all of life could have started on earth without the intervention of a god... Um, equally god could have started the process. (Harry, First, No)*

Apart from attending religious gatherings, a few students also underwent personal research as part of their active exploration. There were a couple of participants who used YouTube as a medium for research. Reece explained how he liked watching videos about atheism and said, “it’s like an intellectual pursuit”. Brenna was similar to Reece. She talked about watching debates on religion on YouTube and how it was a good distraction from her studies:

> *I could watch the You Tube videos so you sometimes felt like watching debates of like some, debates on religion and all sorts of topics but that probably more firmly sort of made me realise that actually yeah, I was an atheist (Brenna, Final, No)*

Reading was another platform that participants used to explore spirituality:
I think I read The God Delusion quite early on... And, I don’t know, like, at a young age, um, they resonated with me. (Ethan, Final, Sp)

I read a lot as well and sort of just, um, especially online like reading, ‘cos there’s English translations of things which is nice (Harry, First, No)

Moreover, exposing themselves to certain figures was part of some participants’ active exploration. Reece said he attended a talk about medicine and spirituality from a doctor who is now a Bishop. The talk included topics around “how do you reconcile believing in god and being a doctor… praying for patients… and faith healing”. Ethan was another student who exposed himself to a certain figure, specifically Chase Harris, whose thoughts Ethan resonated with including “how religion can be bad for a society… and how you can have spirituality without religion”.

One participant discussed how his active exploration came to an end. For Harry, he became busier and had other things to focus on:

Um, sort of at eighteen I got a job and was working and had actual life to focus on....There seems to be no progress that can be made... it gets into a bit of a circular argument and that kind of gets boring (Harry, First, No)

Other sources of influence

Many participants noted that their cultural or religious upbringing had an influence on their own spirituality:

I have three older siblings who didn’t believe in God either and that was probably one of the reasons that I stopped believing. (Brenna, Final, No)

I sort of was raised um, that way [Christian]... And so, I think that empowered a lot of my spirituality. (Adam, Final, Sp)

And then, also, I think, um, in more recent years, I’ve started to reconnect with my, my Asian heritage and culture... Um, and I think, through that, um, ah, I’d start to open my mind up more to, to spirituality. (Ethan, Final, Sp)

Two students talked about dismissive behaviour towards religion within their family:
That’s kind of why I’m still like not like totally jumping into Christianity fully ’cause I’m like, still like a lot of apprehension. (Iris, First, Sp)

So I sort of think like, maybe subconsciously had her influence been like “Oh, it’s just, you know mumbo, jumbo.” Like, but I sort of feel as though, as an adult I’d like to make my own kind of opinion on it. (Riley, First, Sp)

Many participants also discussed the role of spirituality in friendship dynamics:

The group who I socialised with at school entrenched me very much in a non-religious quite an atheist camp. Um, so I think I was probably quite militantly um you know not religious um after that. (Brett, Final, No)

[My friends talked about] how could someone believe this? What would lead them to believe in um, like Christianity say? Um, how they just defend it at all, at all costs? Like, how do you ah, like how, how’s it best to argue? What, what’s a good reason for belief. (Reece, First, Sp)

Two participants mentioned being invited by their friends to religious gatherings and it having an effect on their spirituality:

One of my Christian friends got me to go down there. Otherwise I probably wouldn’t have gone. (Reece, First, Sp)

I’d also attribute it [being more open to spirituality] to um, like a lot of my friends come from Christian backgrounds and I’ve been introduced to the church background (Iris, First, Sp)

Another participant, Lucy, talked about how her friends back when she was eighteen, helped her reach a life-changing moment in regard to her faith. In her words,

That was the first time when people came to me and, you know, let’s read the Quran, let’s understand it, what it’s actually trying to say... And it was really, it was actually a moment, I feel like it was quite, it was changing everything. (Lucy, Final, Re)

For a couple of participants, religious schooling had an effect on their spirituality. As an example, Brett mentioned that he initially believed in God. He said, “I was just like oh well they tell me there’s a god so there must be a god”. For Troy, his Presbyterian high school was where his “basis of most things to do with religion come from...which also, kind of
delved into spirituality as well”. For Rose, she talked about determining her own beliefs in relation to her Christian upbringing. She emphasized that it was important for her to figure out her beliefs as opposed to plainly absorbing the Christian ideals she was brought up in. When asked if she was encouraged to this, she acknowledged the role her school played. In her words,

_I guess, well, for primary school, all of my primary school, I went to a Christian, a Protestant-Christian school... And there was huge emphasis on that kind of thing every day._

Another participant, Chase described how in high school “science sort of took over” and his religion’s teachings about biology and evolution were no longer held tightly by him.

4.3.1.3.2 Finding a Position

Following on from student spiritual influences, this section reports the position that students have found themselves in regarding their own spirituality. Some said that their position was a choice. It was also revealed that some students assigned themselves a label as a way of defining their position. However, with other students, it was suggested that they ‘might’ call themselves a certain label. This section also covers explanations from students that reveal what position they resonate with.

A few students suggested that the position they are in with their personal spirituality was a choice:

_I knew from a young age, like, it had to be a personal decision [becoming a Protestant], otherwise it didn’t mean anything. (Rose, Final, Re)._  

_Why I choose Buddhism was because it was, for me, it was a bit more open and accepting. (Angel, First, Sp)._  

Natalie also alluded to making a decision and expressed concern about whether or not she made the right choice. In her words,
So I think that underlying, there’s always this oh God I hope that I haven’t made the wrong decisions in what I believe or what I understand is reality. (Natalie, Final, Sp)

For a couple of students, it is suggested that they have landed on a position in terms of understanding of their own spirituality. More specifically, they gave themselves a label. When talking about his journey of understanding, Adam said, “I have sort of moved now into what, what I would call sceptical humanism” (Adam, Final, Sp). Another student, when explaining her own journey of understanding, said “that probably more firmly sort of made me realise that actually yeah, I was an atheist” (Brenna, Final, No). Atheism was also something that resonated with another student. In this quote, he explains what atheism means to him,

*I just don’t think that there’s a God… I just haven’t seen enough things that convinces me that there is a God…that’s purely what my atheism is. (Ethan, Final, Sp)*

Other students were unsure of assigning themselves a label. For example, Brett said that he is not religious. He made it clear that he does not believe that “there’s a hell of a lot more to life um than what you know, we just physically experience” and that “there’s something separate to the body and the brain”. However, he explained that there is an aspect of spirituality that he appreciates. In his words,

*but I suppose, you know, to the extent that you know, I’m part of a larger community and a larger society and a large work, or I suppose there’s kind of maybe that aspect of um spirituality that you know, I sort of maybe am somewhat more aware of.* (Brett, Final, No)

Another student showed uncertainty with what label he would call himself but made it clear that he was not religious. He proceeded to explain that for him, being spiritual “might mean of looking up and seeing something beautiful and being amazed”. He said,

*I don’t know [if I would call myself spiritual]. Again, it depends on the definition. If, if spiritual is what I’ve been explaining then, yeah I definitely do have those perceptions* (Reece, First, Sp)
Like Reece, Riley also loosely held the label spiritual. She said, “I do like the spiritual one…I try and be aware of the bigger picture and look after myself and do things for myself and take time for myself. If that makes me spiritual, then yes" (Riley, First, Sp).

This last group of students provided explanations of their position. The examples that have been included show that the participants have considered different elements of spirituality, such as connection, a higher being and certain church teachings, which reflects the position they resonate with:

> how I sit within that [definition of spirituality] for myself personally, um...I guess I see that as a connectedness and I’m not sure myself now how I would describe that as being something greater than us as individual humans in a collective group or just the sense that we choose to, or we thrive best in relationship and that’s the connectedness. (Natalie, Final, Sp)

> So, for me, the higher being, higher powers and stuff doesn’t really do it for me. I believe in, like, I wouldn’t call nature a higher power... they’re so much more powerful than, um, what we could ever be... Nature always gets the final say at the end of the day. (Troy, First, Sp)

> Um, so essentially I can’t prove there’s a god... Nor can I reasonably disprove there’s a god... So I think it’s, you know, I think it’s quite hard to be an atheist because how can you prove a negative? and so I land in the middle ‘cos I can’t answer that question. So...there may be one there may be many, there may be none. (Harry, First, No)

> Um, yeah so the, the like the main parts I probably wouldn’t believe in [in Presbyterian teaching] is like the whole, how it began sort of thing... Um, but, probably like the newer stuff sort of showed like, say last, or the, you know the old testament, like sort of around the Jesus time. It kind of makes more sense... It’s something that you can still take away to everyday life. (Chase, First, Re)

4.3.1.3.3 Turning Point vs Gradual Change

For some of the participants, the personal journey of finding a position was prompted by specific events, marking a turning point. For others, it was more of a gradual process.
Two students told stories about evangelist-type experiences which marked a turning point in terms of how they saw their own spirituality. For Henry, it started when “this group of people that went around the University and they did surveys on spirituality and that kind of thing and then they would kind of start showing you like things in the Bible”. This group then invited Henry to their church which was an unpleasant experience. In his words,

*I realised that they were kind of, like basically just a cult so yeah it was kind of not a great experience and then kind of had to like cut that off.*

(Henry, First, Sp)

Following this experience, Henry began thinking about what church is about which lead him to make a conclusion about religion. He said,

*There’s just so many different religions that it’s like you don’t, how would you know what the truth or like… it’s not everything, like you don’t necessarily need to hold it up as like the ultimate kind of word I guess*  
(Henry, First, Sp)

Adam also had an evangelist-type experience. For him, he was stopped in the middle of the road by a stranger who said to him,

*Your search for and your wanting to learn more about God is in the wrong place and if you try to search for God more you’ll lose them forever, in the next year you need to leave the Church and forget about the Church for a long time and later on in your life God will come back into our life and it will*  
(Adam, Final, Sp)

Adam claimed that this made him think more about his beliefs and debated that it could have been a self-fulfilling prophecy rather than purely being a “message from God”. In his words,

*Like you could argue that you know, that was a message from God and that was predictable one day I will… but you could’ve also argued that this person saying, I was going to over think my beliefs my stuff, made me over think my belief etc*  
(Adam, Final, Sp)

For two students, they mentioned that school marked a turning point for them. As an example, Harry talked about how his frustrations with the religious education he was receiving from his state school made him “quite active into just looking at different things” from when he was ten until eighteen years old. He made it clear that older figures at school
“weren’t very good at fielding questions. Or they weren’t very positive about questions being asked”. Chase also talked about how school influenced him. While still identifying as religious currently, he mentioned his appreciation of science over certain elements of religion. In his words,

*I think it was like Year 10 or something, we did a, like a bit on evolution and then getting into Year 12... [science] sort of just took over. Like I didn’t want to think about it... It just kind of happened.*  (Chase, First, Re)

Lucy told the story of going through a rough time when she was about eighteen which prompted her to ask ‘why’ questions. Then she began going to a group with her friends where they read and discussed the Quran. This group “was changing everything”, she said. She followed on with,

*It was just changing the way I see things... So, I wasn’t as, this positive... about life, before*  (Lucy, Final, Re)

Leaving home for university proved to be a very important stage in her life as expressed by Rose:

*When I’ve got complete freedom to kinda do what I want and believe what I want... this will show me, kind of, who I actually am, and, so, I did go away, and, um, I got really, a lot deeper into the faith* (Rose, Final, Re)

While others had specific pivotal moments, which marked the start for them finding their position, a couple of students attributed the start of their journey to maturing and being gradually exposed to other perspectives:

*I think as I got a bit older I sort of thought about it a bit more and developed my own opinions with it... more open to listening... generally softened* (Brett, Final, No)

*I suppose, up until I was about Year 5, so I’d be like, 10 or 11 or something, um, I don’t really have much spirituality. There was, um, no religion or existence of spirituality in my household... Um, through Year 5 to Year 13, um, I kind of thought about it more, the thought-provoking
lessons and religious education. Um, it kinda just prompted me to at least have a think about what I believe in. (Troy, First, Sp)

For Natalie, she said that “developing as your own person and having explored life” was what helped her find her position. Ethan was similar to Natalie, referencing maturity:

With maturity and with, sort of, um, having more experience... the version of myself that I, I became more comfortable with was that, you know, like, you can reconcile, um, spirituality without actually believing in a God. (Ethan, Final, Sp)

4.3.2 Spirituality and Healthcare

This section reports on how spirituality and patient health are related. It also covers the place of spirituality in healthcare delivery and factors to consider with integrating spirituality into healthcare.

4.3.2.1 Spirituality and Patient Health

This section reports participants’ answers to the question, “How do you think spirituality could impact patient health and wellbeing?”. As explained by students, spirituality: could both be a positive or negative aspect of a patient’s life; is linked to patient’s mental health; can affect medical decisions; could guide the patient’s lifestyle and health behaviours; and could provide a framework to help patients see direction and interpret their illness journey.

Spirituality having a positive impact on patients, namely hope, strength, confidence and comfort, was commonly brought up by participants:

People need strength and hope, so, hope either that everything’s going to be all right in the end, or hope...that there’s a light at the end of the tunnel, and just strength to get through it” (Rose, Final, Re)

[Spirituality] gives them something to lean on that isn’t necessarily just themselves or just the people around them. (Brett, Final, No)

Spirituality is important in that sense that it makes them positive...it gives them more confidence to go through anything. (Lucy, Final, Re)
They [my grandparents] were both quite religious and I think they sort of drew a lot of peace around the end of their lives. (Brett, Final, No)

In addition to spirituality positively affecting patients, one student talked about its potential negative impact. Brett said that “in patients where that belief [in the afterlife] is perhaps shaken, it sort of maybe can give them a bit more uncertainty and unease”.

While others talked about spirituality affecting health, Talia discussed how illness can affect patient spirituality:

And, that if, it [illness] affects, like if their spirituality’s affected...then that’s important for them. And that, like that should be respected. (Talia, First, No)

Two participants drew a connection between spirituality and patients’ mental health:

The spiritual health is directly contingent on the mental health... When they’re [patient with schizophrenia] having an episode, it’s going to be hard to be a spiritual person... I think it’s like a concept your mind brings out. It’s, it’s an internal mental process. (Reece, First, Sp)

If something was off in your spirituality or, your religion or whatever it might be, that that can very easily start affecting your mental health...and that the, like the amount it affects it is different for everyone as well. (Talia, First, No)

Two participants identified the role spirituality has in how patients and families make medical decisions:

A parent or people will refuse to take pharmacological you know, like pills to take things when they prefer prayer or exorcism or something. (Brenna, Final, No)

Someone’s beliefs can prevent them from getting a certain treatment. (Henry, First, Sp)

Also mentioned was the effect that spirituality could have on a patient’s lifestyle:

For a lot of people, it’s a huge part of their, you know, social life and health behaviours. (Brenna, Final, No)
Perhaps, for them, it’s [spirituality] a way of thinking, well, “I need to look after my body which has been given to me, and it’s my, um, my responsibility to look after it… So, you know, when you leave this earth, what have you actually done to make it a better place?... And, so, that can be, maybe, a motivator for people to stay alive, to keep in a healthy state, to be able to fulfil their purpose on earth. (Rose, Final, Re)

Two students elaborately explained how spirituality could provide a framework for understanding the world, and understanding illness which consequently affects prognosis:

[Spirituality allows patients to] to better interact with others, to feel heard and to feel a sense of either hope or I guess a sense that they know where things are going for themselves, not necessarily for what’s going on in the hospital… but that they know that for themselves, they are connected and they’re held… (Natalie, Final, Sp)

their spirituality will affect how much pain they think they are in and how much um, stress it puts on them. How much they need, or how much they feel they need to take time off and things like that… And then because stress leads to you know, a response that changes how quickly you get better and things like that. (Ethan, Final, Sp)

Talia acknowledged how not being spiritual limits her understanding of how spirituality might affect patient health:

It’s difficult to imagine like the direct mechanisms when I’m not spiritual (Talia, First, No)

4.3.2.2 Healthcare delivery

Well I personally think that you can’t take, like you can’t entirely remove spirituality from wellbeing… since we are primarily here for the wellbeing of people so I think it is important because I think it’s something that we need to do better within healthcare. (Natalie, Final, Sp)

The quote portrays one position on spirituality and health – that spirituality is an intrinsic part of health, making it the doctor’s role to attend to it.

This section reports on what participants think about spirituality in terms of the doctor’s role. It also covers the potential effects of integrating spirituality into healthcare, as articulated by the students.
4.3.2.1 Role of the doctor

Many participants acknowledged the importance of recognising the role that spirituality might have in a patient’s health:

*It is part of our job to recognise that there are other parts of people that play a role in their health.* (Natalie, Final, Sp)

*I think it’s just being aware of that as like a possibility... I think maybe it will be easy just to get caught up in the physical stuff... but then we just have to consider that like things could be going on in like other hemispheres of their life and that there could be other ways we could help them other than just giving them drugs or physiotherapy or whatever (Iris, First, Sp)*

Ethan also recognised the importance of spirituality among patients but emphasised that the doctor’s role is to primarily attend to the physical wellbeing of patients. In his words,

*We need to realise that our role in their health is, is limited to physical health. But that there are other aspects of their health that are important, and spirituality is one of those aspects.*

Being a doctor is “about providing the best care possible. And if that means putting patients in contact with their chaplain or their religious advisor then so be it” (Reece, First, Sp). This quote exemplifies that participants are aware of what a doctor’s role is in terms of identifying patients’ needs and referring them to more appropriate services that attend to spiritual needs. Many students shared the same opinion about a doctor’s primary role in this area being referring on to spiritual care experts, but also highlight the fact the doctors have limited ability in this part of patient health:

*I think you should enquire about it. But when it comes to, you know like, seeing to it, I, I don’t have any knowledge in those areas. So...I think that somebody who is knowledgeable about the spirituality or belief would be best suited... I wouldn’t want to do more harm than good. (Talia, First, No)*

*I’d be conscious of to you know make sure the patients have access to the spiritual services and making sure that those who are religious you know, have access to the Chaplain... But you know I don’t know if*
there’s a lot that I could do myself with the patient that would always benefit them. (Brett, Final, No)

[Doctor’s should] acknowledge there’s a problem and send them to people who are experts in that realm of health… I think it would be hard for us to engage properly in every type of spirituality. (Harry, First, No)

Obviously they’re [doctors] probably not the right person to like fix it or alter it, but definitely to um, recognise it or um, just even ask how’s your spiritual wellbeing or something and then getting a spiritual leader or referral or something… Cos I feel like if you, because there’s so many different types of religions and everyone interprets religions in different ways and then other people are spiritual without being religious…and so, knowing all of it, would just be too much I think. (Chase, First, Re)

Rose brought up a similar answer to other participants but implied that certain situations simply warrant a doctor’s presence and that a referral is not always necessary. She explained,

In practical sense, it’s about knowing, you know, in your hospital, where are the chaplains, or who can they talk to, or what does this person need - do they need just a listening ear for 5 minutes or do they need a priest to come and see them, kinda thing? (Rose, Final, Re)

4.3.2.2.2 Potential effects

A small set of responses addressed the topic of the potential effects that spiritual care would have on the patient, and the doctor-patient relationship.

In terms of effects on the patient, Natalie talked about an increased sense of hope and ability to cope. In her words,

I’ve worked in Hospice and Oncology and palliative care for quite a period now and you do notice that when people feel spirituality or religiously, like they are acknowledged and have that, are free to have that connection within their healthcare, there is a greater sense of hope or there’s a greater sense that they can cope. (Natalie, Final, Sp)

It is apparent that participants acknowledged the effect of spiritual care on the doctor-patient relationship. If a patient’s spirituality is not recognized, Riley said that “you run the risk of creating another barrier between yourself and your patients”. Similarly, Brenna talked about the importance of covering these topics in a non-judgmental way, “otherwise you’ll never
find out or they won’t follow your treatment plan or you know, you’ll just come up against a brick wall and they won’t feel like they’re being like, respected or included in the conversation.” Natalie reflected on her experience in her palliative care attachment and said that holistic care increases engagement from the patient:

\[\text{Palliative care has been fantastic because they actively approach people with acknowledging that spiritual care is important within their treatment or within their process of their lives coming to an end and the sense that family or friends are an important part of that journey and I think I’ve noticed that the most there, that when we enable people to express some aspects of themselves like spirituality or religious practices, they tend to engage a lot more with their health team or their health community. (Natalie, Final, Sp)}\]

Iris also talked about the benefits of integrating spirituality into healthcare for both the patient and the doctor-patient relationship:

\[\text{It’s important to talk about spirituality with your patients because you will treat them better, they will feel that you care about them more and you’re gonna get better health outcomes for them (Iris, First, Sp)}\]

4.3.2.3 Other Factors to Consider

This section reports on the factors that medical students in this study consider when it comes to integrating spirituality into healthcare. These factors include: the importance of patient-centred care; comfort and preparedness among medical students; resource demands; and situations where spiritual care is relevant.

Patient-centred

This section covers participants’ comments related to humanised, patient-centred care and the importance of recognising the variety of beliefs among patients:

\[\text{I think the first thing is to recognise that they are human...And, actually, recognise that their beliefs and anything about them, pretty much, is valid (Troy, First, Sp)}\]
A doctor’s role is to operate within the framework that’s set before you...So, yeah I wouldn’t let my, my opinion cloud that sort of judgement” (Reece, First, Sp)

At the end of the day, it’s meant to be a profession around the patient, you know, not around us... we pay a lot of lip service to patient-centred care but I don’t actually think we do it all that often. (Brett, Final, No)

It seems that many participants were in agreement that when it comes to the impact of spirituality on patient health, it is “an individual thing” and that “everyone has different views on it” (Chase, First, Re). Likewise, Harry talked about how “it can be really important for individuals”. Troy gave the example of his uncle who has different needs to his sister:

My uncle is the most blokiest bloke... He'd think it's bloody strange if you asked him what his spirituality is and if it’s important to him. But to other people, like my sister, it’d be very important” (Troy, First, Sp)

Interestingly, when talking about her experience in her rest home placement, Angel pointed out that it would have been wrong to go into spirituality with a resident who was not inclined that way, implying a moral component to spiritual care:

Going into spirituality, like that pathway wouldn’t have been like the right thing to do (Angel, First, Sp)

Another student, Iris, expressed that she would rather ask all patients about the importance of spirituality to their healthcare rather than potentially missing some people out:

I don’t know how many people it’s gonna like be important for but maybe like two patients you see a day that might be important for and you will treat those two patients better because of asking. (Iris, First, Sp)

Comfort and Preparedness

Other than the importance of spirituality in some patients’ health, it is also practical to consider how comfortable and prepared future doctors perceive themselves in meeting this need.

A few participants expressed ease and comfort when asked about the idea of addressing spirituality as part of a patient’s health:
It is an easy question. (Angel, First, Sp)

I’ll often ask patients… like what motivates them, sometimes you know when you ask that, religion will come up you know… and I don’t feel uncomfortable doing that. (Brenna, Final, No)

When asked if he is comfortable with addressing spirituality as part of a patient’s health, many students made a point of being aware of their limits:

While admitting that I’m not an expert and would have to sort of preface any discussion I had with the patient saying “This isn’t my area of expertise.” (Harry, First, No)

I don’t feel as though I myself really understand it, maybe that well. (Riley, First, Sp)

I wouldn’t [engage in spiritual care] now but hopefully one day I would. (Iris, First, Sp)

Resources

Two participants mentioned the challenge of spiritual care being more resource intensive:

It’s gonna take you like more effort and time. (Iris, First, Sp)

We’re in such a high stress, limited resource environment…we still don’t have the funding to have enough people in the team to, you know, cater for these aspects… if you’re good enough to go home… even though there’s so much more we can do for your recovery, like, you’re just going to have to go home, and make that bed available.

Time, place and patient

It is apparent that participants are aware of the situational importance of spiritual care; how time, place and the patient all have to be taken into account:

I think there’s definitely a time and place (Troy, First, Sp).

Probably better fitting in a hospital say, where someone’s sick versus in a GP clinic when you walk in for fifteen minutes. (Chase, First, Re)
Of note, a couple of participants included in their response which patients they think might benefit more from spiritual care, namely religious patients and those with serious illness:

*Spiritual guidance from a pastor very important for them [Catholic patients] and for their understanding.* (Angel, First, Sp)

*I know some people um believe that you know their religious kind of beliefs can shape their kind of decisions… it’s something you should be aware of.* (Riley, First, Sp)

*I do understand that in like serious illnesses such as cancer… a lot of people do get Priests and just to come and talk through and it’s like, it helps with both coping and healing for them.* (Angel, First, Sp)

*Maybe if it was a palliative care scenario… Then I would definitely, I’d definitely talk about that.* (Reece, First, Sp)

Interestingly, Rose acknowledged the importance of identifying which patients would be receptive to spiritual care and how it is best to let the patient lead in these circumstances:

*Some people like it that you acknowledge their non-physical side. But if you picked your wrong moment or the wrong patient, you know, people are thinking, “look, why are you asking all these deep and personal questions?... I want my physical issue fixed”... it’s got to be patient-led.* (Rose, Final, Re)

**4.3.3 Spirituality and Medical School Experience**

This section covers the presence of the topic spirituality within the medical school experience. This includes what teaching students have received about spirituality, as well as opportunistic learning about spirituality which only some students might experience due to the variety of learning contexts medical students find themselves in. Additionally, this section reports the impact of the medical school experience on students’ understanding about spirituality. It also includes medical students’ accounts of thought-provoking experiences related to spirituality.

**4.3.3.1 Teaching received**

**Explicitly Stated**
It seems that most of the explicit teaching on spirituality and health, that the participants have received, has been in the field of Māori health. Students often referred to the Te Whare Tapa Whā Māori health framework:

You can use that outside of Māori patients. (Ethan, Final, Sp)

For the patient to get better, you need to have good spirituality as well as physical, mental and social, or family. (Chase, First, Re)

Adam recognized how the Māori department does really well in teaching students to consider the patient context:

A lot of what they [the department] do is to think, like well you need to be thinking of the context of the patient and don’t forget to always think, well why do they think that, where have they come from (Adam, Final, Sp)

In terms of Pacific health, Reece and Angel briefly talked about their experiences from Pacific Health Immersion Day and how they learnt that “in Pacific Island communities it’s very important, Christianity” (Reece, First, Sp).

One student, Talia, also talked about learning in Early Professional Experience (EPE), about how “one person might consider themselves spiritual in some ways. And, other people, like their spirituality might be like a religious kind of spirituality”.

Related Topics

It seems that med students receive teaching about topics related to spirituality. When asked the question, participants either imply that they have not received explicit teaching or specifically claim that they been taught elements of spirituality.

A few participants talked about receiving teaching about student wellbeing which they claim as related to spirituality:
More for ourselves than anything else...the prevalence of burnout and things like that, in terms of, um our own both mental and spiritual health. (Troy, First, Sp)

I guess indirectly... we’ve had stuff about reflection and we’ve had stuff about mindfulness and stuff about like your own student wellbeing and stuff like that in EPE which I guess is all connected to spirituality. (Iris, First, Sp)

Another area that participants seem to relate with spirituality is respect for patients:

Implicitly in student and professional conduct to respect other people. (Natalie, Final, Sp)

Like informed consent, that kind of thing I guess but sort of being ethical... making sure that a person’s always like comfortable... I don’t know if that’s necessarily like spirituality or whether it’s more just sort of um...honouring a person’s rights but I mean I guess they’re kind of the same thing. (Henry, First, Sp)

Implied spiritual teaching was also delivered through the subject of Māori health:

Tikanga practices around people’s health and wellbeing and I think those are all elements of spirituality. (Natalie, Final, Sp)

We get some teaching on cultural confidence I guess, specifically with regards to Māori Health practices which can be spiritual in nature. (Brenna, Final, No)

Little teaching or no teaching

While some participants could identify what teaching they have received, half either said they had not received teaching or only little teaching or were unsure:

Potentially? Can’t remember. Nothing springs to mind. (Harry, First, No)

Yeah, I’m sure we probably had a couple of sessions in ELM... I do remember, yeah, learning about spirituality and the distinction. And it’s right there, in the, um, Te Whare Tapa Wha... In terms of, um, ALM, I don’t think so. (Rose, Final, Re)

Sufficient teaching
A small number of students gave their opinion on how well medical school was doing in providing teaching on spirituality. Natalie said, “I don’t necessarily think that we do a terrible job at the moment”. Likewise, Rose commented that “it’s sufficient as it is” and follows on by saying that doctors do not need to be “spiritual experts”.

4.3.3.2 Opportunistic Learning

This section covers opportunistic learning about spirituality which only some students might experience due to the variety of learning contexts medical students find themselves in. It seems that through opportunistic learning, students have gained more understanding about spirituality as a concept and its place in healthcare.

A few participants described their encounters with patients who had different spiritual beliefs which in turn increased their conceptual understanding of spirituality. Regarding her rest home placement, Iris said, “we have to do an interview on one of our rest home patients, so we have to ask them about spirituality”. Talia said she found it interesting when a resident said she was raised Anglican “but she didn’t stick to like just the Anglican beliefs. She, you know she had her own relationship with god… And that, that worked with her”. Another student, Chase provided an account of a rest home resident who was not religious but accessed services from a priest anyway. In his words,

_He said that he, he’s not spiritual in any way… he talks to the priest every now and then but it’s more just for someone to talk to… they’re just sort of therapeutic listening I guess… (Chase, First, Re)_

Some students also described tutorial discussions around spirituality:

_Everyone had a different sort of idea of what spirituality was. (Reece, First, Sp)_

_It’s not formal learning… It’s not in the curriculum or, you just end up talking about it anyway. (Chase, First, Re)_

One student, Rose also described an encounter she had with a doctor who believed “there’s no such thing as spirituality…it’s all psychology”.

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As captured in the interviews, participants witnessed different clinical scenarios where spirituality was considered which served as learning opportunities:

*All the learning’s just been very organic, like just seeing how patients deal with it and seen it in the work environment rather than always um... something that we get formally taught about... seeing occasions where the doctors, or something like that, has identified a need and been you know like oh, you know, we’ll make sure the Chaplain comes and visits you... um like saying a wee karakia and stuff like that.* (Brett, Final, No)

Lucy described witnessing spiritual care but also commented on the infrequency of having spiritual support figures in the hospital:

*Māori people have got support person type... Or the priest has come... But you don’t really do it routinely, like, you know, it’s probably when someone just come and ask for it.* (Lucy, Final, Re)

In his interview, Ethan expressed appreciation for the spiritual services in the hospital and how they made him reflect on how doctors approach healthcare in a very different way:

*You start really appreciating the role of spiritual services in the hospitals... you flick back to a, a note that a social worker or, like a, like a pastor writes in the patient’s notes... it’s not until you flick back in those notes... and the patient’s like, “oh, you know, doesn’t feel listened to, feels like the surgical team aren’t writing notes, aren’t being thorough because they’re in and out in the morning, and we don’t see them again... then you start realising, holy shit, like, yeah, we’ve probably saved, like, as a surgical team we’ve probably helped this person not have sepsis... But they still really don’t like us. And they’re probably going to leave hospital with a distaste and a distrust of medical services.* (Ethan, Final, Sp)

As described by Natalie, some doctors implicitly incorporate spirituality into healthcare delivery:

*“Would you like to talk to anyone else or is there anything else we could do for you” and I think their [doctors] underlying meaning is often are there any chaplains or people that you want to talk to or are you, is this, how else would you like to cope with this outside of medicine but not explicitly asking those questions.* (Natalie, Final, Sp)
While some doctors were implicit in their delivery of spiritual care, others were explicit, specifically in the Oncology ward and Hospice as experienced by Natalie:

_The Oncology Ward here in Dunedin I think are fantastic and not just the doctors explicitly talking to patients about that aspect but also the palliative care team, the nurses and the other staff within that department... Um Hospice as well have a, I guess a whole team that is focussed on spiritual care... they don’t just, they don’t only deal with the patient but they also provide counselling and spiritual care for family after their loved one has died._ (Natalie, Final, Sp)

One of the participants, Rose, gave a narrative about an experience she had while she was on elective which gave her the opportunity to reconcile her Christian identity with her professional identity:

_She said, “pray for me, pray for me.”... And, and she’s a Muslim ... I did pray for her... after everything was all over, she called me over again, and she gave me a big hug, and she said, “oh, it was, it was your prayer, it was your prayer that delivered my baby”... So, if you put a, kind of, a Venn diagram of Islam and Christianity, I made sure I kinda stuck in the overlap, rather than say, pushing things toward my side... I was comfortable with what I did._ (Rose, Final, Re)

4.3.3.3 Impact on Students

This section describes how participants’ medical school experience have changed their understanding on spirituality or if they have had thought-provoking events related to spirituality.

When asked if the teaching they had received added or changed their views on spirituality and health, many participants claimed that they now have more awareness and a broader understanding of the topic:

_[Hāuora Māori Week] prompted a lot more understanding about like spiritual and emotional awareness and family awareness in terms of your patients._ (Iris, First, Sp)

_I guess like beforehand, spirituality was always for me like something that was connected to religion or like beliefs... But afterwards..._
spirituality could be anything the other person thinks it is. (Talia, First, No)

For a few students, medical school teaching reinforced the importance of spirituality in health:

Highlighted that it’s important. (Angel, First, Sp)

Māori week came around and they explained it, they explained it quite well... you know if there’s no spiritual, there’s no overall health. Um, and so that’s probably like the first time that actually clicked. (Chase, First, Re)

As captured in her response, Rose gained tools on approaching the topic with patients. However, she is unsure if this skill was taught via the formal curriculum or if she acquired it from a Christian Medical Fellowship (CMF), a student-run group focused on medicine and Christianity:

If I do want to, kind of, go into that spirituality line of questioning, I’ll often start with things like, “oh, what gives you hope?” and using terms like, “hope” and “meaning” and “purpose” which are not exclusive to religion or anything... It could have been, actually, part of, um, and I don’t know if you know, CMF like how to integrate medicine and spirituality. (Rose, Final, Re)

For a number of participants, their medical school experience prompted reflections on positive and negative aspects of spirituality.

They may have false hope... God will cure me sort of thing (Adam, Final, Sp)

[There are] relative merits and the benefits that it [spirituality] provides people. (Brenna, Final, No)

How spirituality plays out for patients was also a point of reflection for some participants. For Reece, he thought about how to comfort someone “from a secular world view” when they are on their deathbed. Angel was curious after watching a documentary in EPE about a Muslim family who “made certain types of health decisions that was very, they alluded that it was religious”. It made her wonder “what part of that religion prompted them to make that
decision”. Angel also had a thought-provoking experience when she was in her rest home placement. Seeing patients with dementia made her think about their capacity for spirituality:

> You go to some of the very demented patients... but it’s like when they’re in that state, I just wonder like... do they still understand, you know, they still have all their Bible but they don’t remember anything (Angel, First, Sp)

Reece also had a similar reflection as Angel with his own rest home placement experience. His explanation focused on the source of spirituality:

> I feel like when you’ve got a, a normal functioning healthy brain, that’s, that’s a brain that’s capable of spirituality... does that mean that spirituality is all in our heads and it’s just a, just a construct that is a coping mechanism that’s been used for that process of evolution? (Reece, First, Sp).

For two students, their medical school experience made them reflect on their personal spirituality:

> It probably challenged me to look at sort of the way they view spirituality... perhaps there were aspects of that that I related to more than my more westernised definition... things like that, um, sort of that aren’t necessarily so directly like gods and spirits and soul, all that stuff, but that kind of sense of being part of something bigger. (Brett, Final, No)

> I was um, placed in psycho-geriatric and... it kind of challenging at, at the start eh? ‘Cos um, people are just so broken... it wasn’t a very spiritual experience... it kind of stripped away at the spirituality if anything. (Reece, First, Sp).

Two students provided reflections on spirituality and healthcare. Ethan talked about how it was not until he entered the hospital that he came to truly appreciate that doctors are part of a team that is trying to provide holistic care:

> You realise that you’re only one small aspect of a big team, where the end goal is, is, you know, fortifying every pillar of, of this person’s health. (Ethan, Final, Sp)
Natalie described her worries about the healthcare system which is stretched for resources and how it can accommodate for spiritual care. She provided insight that healthcare professionals, as individuals, can contribute to spiritual care despite the systemic challenges:

Maybe we can’t deal with it yet as a whole institution, as a healthcare system because it does require too many resources that we simply don’t have and as an individual, we can start to make those steps. (Natalie, Final, Sp)

An outlier position was provided by Lucy, who thought that the clinical years of medical school does not allow her time to reflect on spirituality. In her words,

I remember having a patient actually died on the ward. But I didn’t really have time to actually do a reflection or anything ‘cause you have to do all the paperwork... And you have to go on with lives. (Lucy, Final, Re)

4.3.4 Spirituality and Medical Students

This section reports on the place of spirituality in medical students’ lives. It seems that spirituality has a cognitive and behavioural role for medical students. Additionally, some suggest that spirituality has a relationship with their own mental health. A few students talk about spirituality that implies they see it as an external factor that affects health. Other students discuss spirituality in a way that suggests they understand spirituality as an intrinsic discussion of health. For some, spirituality is a source of moral guidance or positive feelings. Furthermore, it seems that students need the right time and space for their spiritual side to foster. A small number of participants talked about reconciling their professional identity with their personal spirituality. Lastly, it seems that spirituality has a relationship with medical students’ attitudes towards health issues.

Part of students’ lives

Participants described the degree to which spirituality was part of their lives. For Chase, spirituality only played a little part in his life. For Harry and Talia, they claimed that it had
no role. Brenna was similar but acknowledged that her response was based on her definition of spirituality. In her words,

*Not in any way that I would define it... I think there would be some definitions that I would sit with but it just depends on what you think the word means I guess.* (Brenna, Final, No)

Contrastingly, for other students, spirituality played a big role in their lives.

*Actually the most important part in my life... I guess I could see I’m Muslim first, and everything else comes later.* (Lucy, Final, Re)

*I think that to be well, for me the spiritual connectedness allows all of those parts [dimensions of health] to be one rather than separated into different parts.* (Natalie, Final, Sp)

**Cognitive aspect**

It seems that for a number of participants, spirituality plays a cognitive role in keeping themselves well. This role encompasses spirituality manifesting as reframing situations, which many participants described as being an avenue to make sense of what is happening, allowing them to move forward:

*It’s nice to be able to just look at the bigger picture and you can find the reason for yourself... So religion provides that big picture... I guess that’s what I learned from Buddhism, it was just like to look at bad things even in a good lens.* (Angel, First, Sp)

*How I link my spirituality to my happiness, is that... when I’m feeling particularly stressed or if I feel like I’m reacting negatively to a situation I’ve experienced, I can trivialise that experience through meditation and through mindfulness, grounding myself in that present moment... my spirituality keeps me happy, you know.* (Ethan, Final, Sp)

*Those struggles will be rewarded... And it could be one of the ways of you going to heaven...And even though you kind of fear that something might fail or something like that... You have that motivation that, you know, it is going to be OK because you believe in God.* (Lucy, Final, Re)

*Relying that God has a plan and a focus, and God has control of the situation.* (Rose, Final, Re)
We’ll work it out eventually, just kind of knowing that and that allows you to keep trying rather than being like oh I can’t be bothered with this, I give up, yeah, so [spirituality is] just kind of like a way of stopping you giving up I guess. (Iris, First, Sp)

You sort of need to take a step back and be like actually, this is not my whole world… There is so much more. (Riley, First, Sp)

When I am unwell or something is going wrong... more of that search for meaning is an important thing so I think that spirituality would have a huge part in that. (Adam, Final, Sp)

Not an organised form of spirituality but like trying to see, see the positives in things. See the beauty in things as well as having the rational mind-set about it [being unwell]. (Reece, First, Sp).

**Behavioural aspect**

What has been revealed in participants’ responses implies that the cognitive role of spirituality can be reinforced by certain behaviours like personal reflection, group reflection, and spending time in nature:

*Reflection is something I’ve only kind of discovered this year... I think that’s related to spirituality because it’s related to kind of purpose and kind of moving forward and like being who you wanna be I guess (Iris, First, Sp)*

*We meet together and ... it’s kind of really good for giving you direction in your week and stuff like that which is good and kind of purpose and stuff like that. (Iris, First, Sp)*

*And I do have my own group of, um, we call it circle, a Quran circle that we meet every week... they keep me sane I guess ... keeps you motivated. (Lucy, Final, Re)*

*I spend a lot of time outside in the nature and I think it’s dwelling on things, again outside of myself and the beauty within our world... if I was not at the hospital on a Saturday, to go for a bike ride and spend time together... I think for me, the aspect of spirituality is in that, is the connectedness and the knowing that we are prioritising time together to build our relationships. (Natalie, Final, Sp)*

**Mental health**
It is apparent that for some participants, the cognitive aspect of spirituality has an impact on their mental health:

*How I keep my mental health... it’s probably quite related very, very close to the spiritual side of things... like I said before, that religion keeps me positive... gives me motivation... having a God that actually cares for you and all those things actually makes things much, much, more easier... to handle.*  (Lucy, Final, Re)

For Rose, she recalled a time when she had depression and how her mental illness affected her interactions with other people. This altered way of communicating with others made her internalise that she was sinning which separated her from god:

*Once I learnt a lot about mental illness and had word for what I had gone through, I mean, I definitely would never have said to another person that what they were feeling was a sin.* (Rose, Final, Re)

The behavioural aspect of spirituality also has an impact on some of the participants’ mental health. For Iris, the practice of reflection is important in keeping herself well:

*Looking at like reflection I think is a way of kind of looking at your emotions and working out kind of how to either change them or move forward from them or like just know that you’re feeling that way and now you want to feel a different way or something that like, so that’s kind of emotions and spirituality is by reflection*  (Iris, First, Sp)

Even though Chase self-identifies as religious, he claims that spirituality only plays a small part in his life. Praying when he is stressed comes under this small part of his life:

*If like I’m having a bad time and I feel like I’m stressed or something, and then I can sort of just um, say a prayer or something, and it can help me like feel less stressed or more at ease... that’s better for my mental state.*  (Chase, First, Re)

In Angel’s case, it seems like both behavioural and cognitive parts of spirituality are related to her mental health. In terms of the behavioural aspect, she goes to the temple and asks for help from the monks. In terms of the cognitive aspect, it seems like “looking for answers” plays a role in her mental health:
I think yeah, spirituality will play a lot of in terms of mental health... Like going to the temples and talking to the... to the monks... they give you very very broad advice... like going and asking for directions and asking for answers would be a process of healing. (Angel, First, Sp)

**Spiritual Health**

When asked how they keep themselves well, some students explained how spirituality affected their health, and others explained how they kept themselves spiritually healthy. It seems like some participants explained spirituality as an external factor that affects health, and others talked about spirituality as an intrinsic dimension of health. This section reports on the latter. It is also important to consider that some students seem to describe spirituality in both ways.

Some participants talked about how they keep themselves spirituality healthy. For Adam, it is largely about “having lots of discussions about meanings” (Adam, Final, Sp). He followed on by explaining how his spiritual health is linked to his mental health. He also talked about listening to a podcast as part of his spiritual health. For Iris, “spiritual health also stems into like the going to church part and things like that and trying to form that relationship”. She said,

> That’s like part of my health as well, like if I don’t go to church or talk about faith or anything in a week, I might be like oh I feel like I really need to do this so. (Iris, First, Sp)

Troy claimed that in terms of spiritual health, he is “at a good point at the moment”. His explanation included,

> As of recently, I’ve had no issues with it... I’ve just had no positives from it either (Troy, First, Sp)

Troy followed on by describing how reconnecting with his Māori heritage was good for his spiritual health:

> My Māori heritage is probably something that makes me very spiritual... that was a very important spiritual thing for me, just to find out where I come from. (Troy, First, Sp)
The following participants talked about spirituality as an intrinsic part of health but claimed that it does not play a big role for their health currently:

To me, definitely the physical pillar, social pillar, the family pillar are just much stronger pillars... than the spirituality pillar. (Ethan, Final, Sp)

I generally don’t feel lacking spiritually...Um, like even though I don’t have much of it, it’s just kind of just adequate for me. (Chase, First, Re)

Moral Guidance

A few participants described their spirituality as something that influences their morals and ethics. These students talked about religious spirituality in particular.

For Rose, her faith affects her interaction with other people. She tries “to put an emphasis on being kind, and being open, and being understanding, on being, um, the way that Jesus showed people how to be”. She also talked about risk-taking behaviours and social issues:

Things like drinking and doing drugs, like, that’s a bit of a grey area...

But, in its truest form, which is how I try to follow, follow Christianity, um, would be those things, things like, um, being against homosexuality, um, abortion, euthanasia. (Rose, Final, Re)

Adam claimed that most of his “ ethics either came from God or came from the Christian Society” that he was raised in. He also explained how moving away from Christianity did not result in moving away from the Christian values he gained. Similarly, Iris gains guidance on how to navigate situations from attending church. She said

I really like the sermon ‘cause it often gives you some really great advice... about like how you should be with your friendships and your relationships. (Iris, First, Sp)

Positive feeling
A small number of students suggested that spirituality for them is a source of positive feelings:

*The worship is great... just seeing how into it other people were and just seeing kind of like the love and stuff and that was really really amazing* (Iris, First, Sp)

*For me it’s more like it’s, it [spirituality] is a useful distraction from sort of stress, like especially from like Med... that comes back into like the things I find to be spiritual so yeah, just like...nature, reading a book, that kind of thing.* (Henry, First, Sp)

*Take your mind off um, all the stuff you’ve got to do. Um and I guess spirituality can help with that as well... can help you like yeah feel better, more at ease... for me, it’s just like the whole like, um prayer here and there.* (Chase, First, Re)

**Right conditions**

It is suggested by a few participants that space and time needs to be allowed for spirituality. For example, Iris prays when there is less disturbance:

*I do it [prayer] at a time generally like before I go to sleep or something when you’re not doing other things, like if you’re doing other things, then your thoughts are probably jumbled* (Iris, First, Sp)

When asked if she has had any thought-provoking experiences related to spirituality while in medical school, Riley talked about her doubts with the school’s intentions related to spiritual growth. It is also important to note that she prefaced her answer by reiterating her understanding of spirituality as having “time for yourself”. Her explanation included,

*One of the things that like the message is that like preached to us is like, “You know, make sure you take time for yourself.” Then I guess, you know embrace that spirituality side of things. But then they [medical school] don’t give us any time to actually do that... It’s sort of like, well when am I actually supposed to take that time... to embrace those other sorts of things that are important to your overall wellbeing.* (Riley, First, Sp)

Troy is similar in the sense that medical school is dominating his life currently. He described siloing his spirituality during semester time. He said,
At the moment, it’s [spirituality] not a lot because Med kinda does, you kinda just go through the motions... In the holidays and stuff you have spare time and it’s great, you can focus on yourself a lot more. But during the semester, you kind of just, um, separate yourself and just go through the motions. (Troy, First, Sp)

Later in the interview, Troy made the point of wanting to take a break from medical school to discover himself or discover his spirituality “which is probably one and the same, to be honest”. In his words,

I need to do, um, probably... take a year off between third and fourth year. And I imagine, during that time, I’d like to go and do some travelling, and just get away and kind of think about it [spirituality] some more... I feel like you have to take some time out for yourself and discover that. (Troy, First, Sp)

For Reece, he described the apparent need for a positive headspace in order to be spiritual:

I think it’s easier to be spiritual when you are happy... When you’re in that sort of nihilistic space, it’s a bit harder to be, to be like “Oh wow, look at the trees.” (Reece, First, Sp).

Professional identity

A small number of students talked about trying to reconcile their spirituality with their professional identity. For Rose, with her beliefs about abortion, she has had to work out what situations she will allow herself to be part in:

Um, like, so, I’m anti-abortion, and I just recently did, um, the obstetrics and gynaecology run. And there’s one section where you can go and watch a termination be performed. And I was, like, “OK, I’m not going to go to that. That was easy.” And then, um, there was a time, you know, you’re in clinic, um, it’s come up several times, maybe where I’m interacting with a patient and I’m offering that as an option, and I’m going through it with them. And I’m thinking, “oh, some, some Christians wouldn’t go this far with their patients.” (Rose, Final, Re)

When Adam was still religious, he recalled thinking about how he could keep his religious identity intact without compromising the doctor-patient relationship:
I was still half sort of religious when I was in the start of Med School and stuff, a lot of questions came up about, if I am religious how can I be myself around patients without sharing that to people… I feel like it must be very difficult for the religious people in Med but also for anyone whose got beliefs, which is everyone, um, to work out how to show them selves into make, make their opinions part of who they are without that being something that they are imposing to a patient. (Adam, Final, Sp)

All of these students talked about religious spirituality.

**Spirituality and attitudes towards health issues**

For two religious students, attitudes about health issues were reported as related to their spirituality. When talking about how she recovers from illness, Lucy explained the complementary nature of her faith:

*I actually want to say that it’s not magic... to get better, you know, you still have to take the medications and everything. But, to go through the feeling of, you know, difficult and all those things that happen to you, I would go with whatever is in the Quran.* (Lucy, Final, Re)

For Rose, she talked about how her belief in an afterlife impacts her attitude towards resuscitation:

*I believe it’s, it’s better, say, to die than to keep jumping on someone’s chest or to live as a vegetable, kind of thing... Cause I believe that there’s something better than life on the other side.* (Rose, Final, Re)

4.3.5 Additional Theme: Training Preferences

With integrating spirituality into the medical curriculum, it seems that medical students consider certain factors. This section reports on what students desire to achieve and learn from a spirituality and health curriculum. It also covers their preferences in terms of teaching style. Additionally, participants shared their opinions on receiving spirituality teaching as related to a doctor’s role. Lastly, students talked about how receptive they would be towards spirituality teaching.
4.3.5.1 Desired outcomes

When asked what they would prefer to be taught about in terms of spirituality and health, some participants talked about outcomes instead of specific content. This section reports on students wanting to: improve student wellbeing; know how to avoid doing the wrong thing; be more confident; improve awareness.

Adam expressed interest in receiving “teaching where it would help people search for their own meaning”. He acknowledged that this would be “important for all health professionals to be able to do that when things get difficult”. He followed on by saying that having “more opportunities to share ideas between people” would facilitate this process. Also recognising the importance of student wellbeing, Brett said “it’s probably a good thing for the med school to encourage you to clarify your own spiritual beliefs”. This way, students will have another source for coping. In his words,

That helps give you a bit of a position of like, it helps stabilise you I suppose when you have challenging times come ahead... I think it’s actually quite valuable to be given the space to kind of clarify and develop your own views um to give yourself that kind of base and solid support structure to um work within. (Brett, Final, No)

For Troy, he does not “want to do the wrong thing”. Similarly, Riley wants to be more aware so she can avoid accidentally saying offensive things:

I don’t want to accidentally be like, “Oh Jesus Christ.” And then be like “Oh shit”... I’d like to be slightly more aware of it so that I don’t... mess up somewhere (Riley, First, Sp)

Like Riley, Angel also acknowledged the importance of the pluralistic nature of healthcare. Because of this, it is important to “advocate that people need to understand, as a health professional, you’re dealing with people with different culture, different religions”.

For Talia, she wanted to gain more confidence:

It would be nice to learn like, like, I suppose just to feel more confident about discussing spirituality with patients. (Talia, First, No)
4.3.5.2 Desired content

I think it’s sort of, I think, you know, it’s kind of that unpacking of what spirituality means and how it can mean different things to different people... and I think also unpacking how it affects their health and how they can, it you know can change what they’re feeling around health... but how...you can stabilise somebody’s spiritual health or spiritual well-being, um as part of treating them in a wider framework (Brett, Final, No)

The quote above illustrates what teaching content participants want in terms of spirituality in medical school: conceptual understanding of spirituality; the relationship between spirituality and health; spirituality and healthcare delivery.

In terms of conceptual understanding of spirituality, a few participants expressed interest in having a “more definitive idea of it”, as articulated by Henry. He said that the idea is “still a little bit cloudy” for him because everyone has different ideas about it. Talia wants to learn about “spirituality from quite a few different cultures, not just the dominant ones”. Riley also wants to learn what “other people seem to think spirituality is”. Likewise, Iris wants to “become aware of what that sort of things means for different people”. She wanted to be “prepared for the possibilities of the person in front of you” when talking about future patients. She also suggested that one way of achieving this is to be exposed by different perspectives.

When it comes to spirituality and health, students mentioned wanting to learn “the ways in which it can affect health”, as expressed by Henry. Riley talked about gaining an understanding on “how that might affect their life choices and their care”. For Angel, she described the inadequacy of simply learning that spirituality is important for health. She desired “case specific stories as to how it was important” but is unsure if it is the job of the medical school:

Yeah and I guess, just being educated about different people but then I don’t know if that’s, I don’t think that’s the role of the Med School.
(Angel, First, Sp)
Another area that participants seemed to want to learn about was spirituality in healthcare. A few students desired better understanding on how to navigate the emergence of the topic. Adam expressed worry about not knowing what to say if a patient introduces spiritual issues:

*The more I get into it the more worried I am by what they are going to say, because I might not have an answer... Yeah and so I guess in terms of the previous question about what would be interesting to have more training, that would probably be in there.* (Adam, Final, Sp)

As expressed by Reece, students want to learn about “a good way of breaching the subject”. This is supported by Iris who said she wanted content on “strategies about how to get like down to that kind of stuff”. Harry also talked about receiving teaching on “how we should ask about it”. For Ethan, he wondered “which patients would benefit from those [spiritual services]” and suggested that students need to be “more comfortable with asking”. Similar to the other participants, Troy wished “there was an easier way to find out what someone’s spirituality or religion was”, and “once you have that information, you can alter your treatment or discussions accordingly”.

For Brenna, she described that “the most important thing is whether there are certain protocols you probably should follow around, you know around sickness and death”. Like Brenna, Troy also wants to learn about protocols:

*A general understanding of, maybe, not even a major amount of information, just like the top 3 things to remember, as a doctor, if you’re dealing with an, um, [for example] Islamic patient... Um, so, for some, I know they definitely told us some cultures, like, if you get a couple come in and they’re of certain faiths or cultures, you speak to the man, you don’t speak to the woman.* (Troy, First, Sp)

Making referrals was also discussed by some participants. For Chase, he wants to know how to transfer skills like referring Māori patients to a kaumatua to other types of spirituality:

*Like just in the Māori context, so I guess you take that example and apply it elsewhere about how um, they want, they might want someone from like their kaumatua to come and speak to them and stuff. So I guess if you just take that idea, and sort of apply it elsewhere... if you have someone from a, a, um, different religion. You might like get one of their elders or um, leaders or something to come in.* (Chase, First, Re)
Harry had more uncertainty when it came to making referrals for patients who are spiritual but not religious:

*More people identifying as being spiritual without religion... And, what, what’s a good way to engage with those people?... Um ‘cos it’s really easy to sort of say, ‘Oh yep, so you might be Christian or you might Jewish’... But if you’re identified as being quite spiritual... I wouldn’t know how to go about helping someone or even who to refer to. (Harry, First, No)*

Lastly, apart from making referrals, Ethan wondered what a “doctor’s role is in a patient’s spiritual health. He also wants to learn what spiritual services exist.

4.3.5.3 Form of course delivery

This section reports on participants’ responses to the question “What form of course delivery would you find most effective on spirituality and health?” Answers can be grouped under preferred styles of teaching and comments on the wider approach.

In terms of preferred styles of teaching, it is apparent that most participants would appreciate an interactive platform. Lucy wants a medium where “you can actually talk about it”. For Reece, he appreciates small groups. Natalie was the same and commented how in small groups “people can’t get as easily distracted because there’s less people around so it’s obvious when you’re not participating and being engaged”. Adam said that having the whole class together would be “too big” and he talked about the importance of “having sort of positions where people can discuss it”. Rose was also for small groups where there is “a tutor facilitating discussion or answering questions”. She also commented on the “pros and cons of small groups. You get louder people and quieter people, and people who have more opinions, and people who don’t”. Like Rose, Brenna welcomes platforms where she can ask questions:

*I’m not the kind of person who would ask questions in a lecture but I’d ask questions in a tutorial if I was confused or didn’t understand why something was a certain way... I think it needs to be because there’s a lot of nuance and yeah, like a lot of things which you know, are hard to*
describe and they require clarification or a demonstration. (Brenna, Final, No)

For Chase, he made a point that “it is definitely not something that you just sit in a lecture theatre and be talked to. And definitely some sort of interaction involved”. Troy is similar in the sense that he would prefer to have a discussion and not just being talked to. He said his questions “won’t be answered unless we can have a discussion”. Iris had a similar opinion:

*I think spirituality and stuff like that is something that’s better discussed rather than people talking to you about it so in tutorial format might be a better way to go about it probably because I think everybody has their own opinions on it and teaching in a tutorial format would allow us to be more aware of people’s different opinions on it and if people discuss it among themselves and I think that people are more engaged in the tutorial than the lecture (Iris, First, Sp)*

Riley recognised the individual nature of the topic and gave the critique that it should not be treated as if it is “black and white”:

*I feel as though it’s a really individual thing and potentially for some people it’s also quite a personal thing. So I don’t feel as though, you know it’s not black and white. So then how can you teach it like it’s black and white? (Riley, First, Sp)*

Other ways of course delivery was also suggested by some participants. Ethan finds value in storytelling from patients as “that would stick in people’s memories”. Another alternative suggested by Angel. She said delivering content through an event could be valuable:

*I dunno if we have enough lectures left to have different lectures but maybe events… like people from different cultures, they come together and do like a little blurb about themselves. (Angel, First, Sp)*

For Iris, she showed appreciation for receiving input from older medical students:

*Kind of like a mentoring way to do it saying, because people, again we’d probably be more likely to listen to somebody who is in clinical years and who is finding it relevant than like a 60 year old lecturer who is like this is really important…you know that we’re gonna be doing clinical years*
A couple of participants wanted a variety of teaching methods. Brett mentioned it might be useful to have “a lecture or tutorial like you know interwoven with you know um part of clinical teaching in medicine”. Talia finds lectures “pretty interesting” and “good for like bulk information”. She also said tutorials are effective for interaction. Harry also recognised the benefits of an integrated approach. As well, he commented on the importance of continuity:

You know a, lecture or two plus a half hour thing [tutorial discussion] once in year 2 and once in year 4 or something, or year 3 just to...you know do it more than once. ‘Cos if you only do it once, you’ll forget it.

(Harry, First, No)

Like Harry, Riley talked about the value of continuous exposure. She said it is not “something you could learn about in one lecture or one tutorial”. It is “something you kind of have to dip in and out of and by, you probably something you only kind of come to understand as you over further and further through your degree, through the process”. For Chase he would appreciate “a constant, a gentle reminder every now and then. Like, to say include a spiritual aspect in your um... when you see a patient”.

Two interesting points were brought up by Natalie. She said that the topic of spirituality should be dispersed across the whole curriculum and that it has to be explicitly stated:

I think it should be part of the curriculum. I don’t think it necessarily has to be a separate part...because it can be brought in many things... and I think though, that it does need to be explicitly stated at the same time. I don’t think that you could say you could let it be an implicit part of the curriculum where people didn’t realise they were acknowledging spiritual aspects... I think it needs to be explicitly stated but it can be woven across many fields. (Natalie, Final, Sp)

Henry was of the same opinion. He said “it needs to be, yeah a bit more integrated into...a lot of things just so that kind of, it becomes quite natural just to have that”.

in a couple of years so if it’s important for them, it’s gonna be important for us so yeah. (Iris, First, Sp)
This section reports on the responses from two questions: “Do you think spirituality and its relation to health and healthcare are important to learn about in medical school?” and “Do you think this teaching should be compulsory or optional?”

Both questions yielded conflicting priorities related to if spirituality and health teaching should be delivered. On one end, participants recognised that it is part of the doctor’s role to address spirituality. On the other end, participants talked about how receptive students would be to this kind of teaching. It is apparent that there are varying levels of interest, opinions and comfort around the topic. Apart from students’ thoughts on the doctor’s role and how receptive students will be to spirituality teaching, other factors to consider include variability of beliefs among students and the logistics of curriculum changes.

4.3.5.4.1 Doctor’s role

*It’s ok to say “No, I don’t want to be it [spiritual]” but it’s not ok to say “No, I don’t want to know about it,” ‘cos it’s an important aspect of the patient’s health.* (Harry, First, No)

*Yeah I think that would be quite important, yeah just if like if there’s something that’s going to have a big impact on how a patient is treated, then that’s quite important to learn about I think... Probably um, more compulsory but I don’t know, yeah I dunno* (Henry, First, Sp)

The above two quotes illustrate that how important spirituality is to patients is something that students consider when it comes to thinking about spirituality as part of the medical curriculum.

When talking about if spirituality and health is important to learn about in medical school, it seems that participants primarily consider the role of the doctor. Based on the responses, the role of the doctor is to focus on the patient and to put the doctor’s own beliefs to the side. It also means treating the whole person to achieve not just patient wellness, but also patient satisfaction. Brett encapsulates this well in his response:
It’s important that doctors, even if they disagree with something or don’t necessarily personally empathise, you know, don’t come from that perspective themselves, I think it’s important that you understand that other people do… Ah that other people come from these different perspectives so you’ve gotta be able to know how to address that if you want to actually treat people in a complete way. (Brett, Final, No)

Iris also articulates this well. She explained the importance of looking beyond the physical ailments to achieve good outcomes for the patient, ensuring that doctors are doing their best:

We don’t always realise that they [spiritual issues] are important because you think oh you’ve gotta treat the person, that’s how they come to you with their pale face and red nose, whatever (group laughter), but like just seeing what possibly could be behind that is really important, not just for kind of like making sure the patient is well again but also making sure that they have a good experience with you and like that you are like a positive doctor for them… they will probably think that you care more if you don’t just do the physical stuff… it’s really important that we try to be the best doctors we can. (Iris, First, Sp)

Other participants expressed similar opinions as Brett and Iris in terms of patient-centred care. Harry talked about how “think it’s important that we acknowledge it’s there”. Likewise, Talia said that “if it’s important to the patient, then you can’t ignore it. Or expect them to deal with it alone”. For Lucy, she shared the opinion that it is essential to be aware of patients’ beliefs:

I think we have to acknowledge that, you know, everyone has a way of coping, and everyone actually believes in some sort of belief system, whatever that is (Lucy, Final, Re)

Brenna took the idea of focussing on the patient further and explained that patient-centred practice can help doctors “meet [patients] in the middle in order to help them improve their health behaviours”. Henry supported this and said that being aware of patient spirituality helps the doctor find “ways to accommodate that kind of thing... and just find some compromising solutions”.

For Natalie, being aware of patient spirituality was more about gaining “tolerance” because “part of our job is to not negatively affect our patients or the people that we deal with”.

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In terms of whole-person care, Riley talked about the significance of doctors doing everything they can for the patient:

_There are going to be some people that are going to benefit by that. So if you are oblivious then, you know potentially you’re not going to be providing everything you could to... you know these people as a person_ (Riley, First, Sp)

For Chase, he described that ignoring the spiritual wellbeing of a patient is insufficient in terms of treating them:

_Like if someone’s feeling spiritually diminished, they’re not, they’re, them as a person...is still going to be diminished if that makes sense?_ (Chase, First, Re)

For Troy, even though he did not mention why, he recognised the importance of learning holistically:

_“You have to get all the science...You’ve got to get all the clinical skills...You have to get all your EPE... and spirituality, I feel, comes pretty close to, I don’t know... EPE I guess. But, um, it is just an important thing to learn._ (Troy, First, Sp)

In terms of the outcome of whole-person care, Adam explained that patients “will leave feeling happier”. His response suggested that patient satisfaction can be achieved by helping patients understand their illness experience which can be done by treating the whole person:

_It is such an important part and of course you want to treat the whole person... Um, and so their understanding of the meaning of what is happening and what it means for them, if they are able to process those questions then they will leave feeling happier._

Overall, when addressing the questions of “is it important to learn about spirituality and health” and “should it be compulsory or optional teaching”, participants talked about patient-centred care and whole-person care. They also described the potential outcomes which include patient satisfaction and patient wellness.
4.3.5.4.2 Receptiveness from students

*I just feel as though, because it’s not, you know hard core science...there’s the risk that people would just be like “Oh, it’s kind of one of those fluffy airy fairy things. I won’t worry about it. And then I think you run the risk of not learning it at all.”* (Riley, First, Sp)

*It’s so variable that it’s hard to like, people perceptions of spirituality, it would be hard to create a curriculum around it.* (Reece, First, Sp).

Another factor that seems to be heavily considered when addressing the questions of “is it important to learn about spirituality and health” and “should it be compulsory or optional teaching”, is how receptive medical students would be to it. Gathering from what the participants said, there is a proportion of medical students that would not attend lectures on spirituality if there was one. Some students suggest that this is because of the type of personalities that medicine attracts. It is apparent that many medical students are scientific-minded and would overlook a topic like spirituality easily because of its perceived non-scientific nature. A small number of students postulated that with increased patient interaction and life experience they would be more receptive.

As articulated by Troy and Iris, many participants suggested that spirituality and health lectures would not be perceived as important:

*Lectures would be the ideal system, but people wouldn’t show up to them...‘cause they only want to go to the important ones* (Troy, First, Sp)

*If we have a lecture on spirituality, people aren’t gonna turn up... there’s a perspective around it that it’s not important* (Iris, First, Sp)

For Riley, if she received optional teaching, she would not pay attention to it as much as if it was compulsory. When talking about the teaching he has received on the topic, Ethan recalled being in Māori health lectures and how they were “snubbed” and how “attendance is really low”. Troy made a point that if teaching on the topic was optional “there’d be so many people who would opt out”.
Talia expressed a worry that if teaching on the topic was optional, “the people who wouldn’t choose to come, would probably be the ones who need it most”. Brett echoed this when he said,

*It’s always one of these things where it’s a bit self-selecting the people who you know, would want to go and be interested in going are often people who are already familiar with the topic.* (Brett, Final, No)

Similarly, Troy talked about how it will be unlikely that medical students would voluntarily learn about the topic unless they received formal teaching. He also made a point that the students who would be interested “would only be interested in certain fields, as opposed to a broad spectrum of ideas, beliefs and spiritualities.”

The following quote by Riley gives insight on a possible reason why medical students do not find the topic important. She suggests that medical students would find the topic “fluffy” and because of the amount of content that these students receive throughout the year, they might doubt how examinable a “fluffy” topic would be compared to everything else. Here, it is suggested that medical students have a leaning towards both scientific and examinable content. It also seems that there is a relationship between topics that are scientific and examinable:

*I feel as though for a lot of people, they might just be like “Oh, it’s not important” yeah, I feel as though there’s, there’s this sort of, the risk of saying “Oh well, it’s not going to be assessed, so I won’t bother going.”... everyone knows that we’ve got, especially like say for med, you’ve got a whole year’s worth of material to examine. Are they necessarily going to examine me on this little fluffy thing? Maybe not. But it’s like regardless of whether they examine us on it, it’s probably useful to know.* (Riley, First, Sp)

These sentiments are shared by other participants. Ethan emphasised that there is a “selection bias” with who enters medical school so as that the students who get in are “particularly biased towards a scientific way of thinking”. Likewise, Natalie said that medical students are “by and large A-students and A-type means that they are very much academic focussed which is black and white learning”. She went on and said that “spirituality is not black and white learning”.

Interestingly, some participants in their interview exemplified this. Brenna explicitly said, “I have a scientific mind”. Additionally, when Troy was talking about his experience of receiving religious education, he made the point that “a lot of those questions you can answer with logic and reasoning… that don’t require a, um, a God to explain them”.

Ethan posed a potential solution on how to generate enthusiasm around the topic of spirituality and health that addresses the perception that medical students have a leaning towards more scientific topics. He suggested that if teaching came from “data…then we’re speaking the same language as I guess what medical students generally speak”. Here, he suggested that evidence-based teaching would be a way forward.

Of note, Iris gave the insight that an “there has to be an attitude change for the teaching to be worthwhile”. She also said that “talking to older Med students that kind of understand that that kind of stuff is important because they’ve had patient exposure”. Interestingly, Brett, an older medical student, in his interview talked about his own shift in attitude:

I think in some ways... people are more open to it after they start in the wards. And I think once they actually start seeing patients, they start seeing what medicine actually means on the ground... so I think, for someone like me, I probably would’ve rubbed it or not have bothered to attend the lecture if there had been a lecture on it in second or third year, but once you start seeing on the ground on the wards, you sort of realise the value of it and are more interested and more likely to engage. (Brett, Final, No)

Ethan echoed this and talked about the importance of witnessing holistic care in action, and how learning it in a classroom setting does not do the topic justice:

I think it’s not until you, you’re in the wards, you’re connecting with patients, and you realise, like, um, you know, like, you can see with your eyes that it’s not the surgery that’s gonna make this person happy. It’s, it’s the attitude of the surgical team, and it’s us considering all the other aspects of their health so that, you know, that they have physio, that they can move, that they’re functional at home, that they have care packages, that, you know, um, whanau care have come to see them or, you know, whatever the, ah, sorta, spiritual or, like, cultural, um, health service, um, has come to see them if that’s what’s important to them. Like, it’s so hard to appreciate that, sitting in a classroom. (Eihan, Final, Sp)
For Natalie, she described the significance of life experience in terms of truly understanding the topic of spirituality and health. She also made the point of it being difficult to diverge from one’s own upbringing or parent’s views on the topic:

_I think that I see how we view spirituality changes with maturity in our own life experiences... it’s very difficult to teach that when a large number have very little life experience... I think that a lot of people don’t know how to explore what they think in this period until they’ve had a lot of life behind them._ (Natalie, Final, Sp)

It is clear that there are varying levels of interest, opinions and comfort among medical students in regard to the topic of spirituality and health. Adam, who repeated third year, was able to experience being in a tutorial discussion about spirituality twice. He reported that the two groups he was part of were very different. This exemplifies the varying levels of interest, opinions and comfort among students:

_It was quite interesting to see the same questions be asked in two different HIC groups... The other group would say, there are no wrong answers, I’m going to give my opinion and so everyone would have these opinions and they go, well I disagree because my opinion is blah. Um, so there were two very very different groups in terms of that._ (Adam, Final, Sp)

Another student recalled an experience which also portrays the varying levels of interest, opinions and comfort among students. For Lucy, she expressed hesitance in incorporating spirituality in the curriculum for fear of students unconsciously hurting others:

_I was in one of those tutorials about spirituality, it’s not like we were talking about religious, being religious and spirituality and all those Alcoholic Anonymous things... And I found the, what in the room was kind of, say that these are ridiculous... Yeah. And, yeah. And I was, like, you know, it wasn’t really a nice thing to say in front of people who are actually religious... Yeah. I don’t know. I probably want to prevent that from happening._ (Lucy, Final, Re)

4.3.5.4.3 Outlier responses

This section covers a set of outlier opinions. For Angel, she considered the logistics of introducing more content into the curriculum. She described the idea of easing the topic in:
The reality of actually having it, you know be able to do something about it, it’s easier to start... being optional and then gradually see what we can add on so compulsory perhaps in the future but that stage, optional, having some people who are motivated about that sort of stuff to do something about it, yeah (Angel, First, Sp)

Interestingly, two students were not overly supportive of fully incorporating spirituality into the curriculum. Although earlier in the interview he described how spirituality could affect patient health, Ethan made the point that competency in spiritual care is not essential in all fields of medicine:

You know, like, you can still be a great ophthalmologist if, you know, you didn’t have any regard for someone’s spiritual health... Or, um, you know, like, I don’t think there’s really a role for that person, um, and, in holistic care, you know. Like, they’re destined for specialised care. (Ethan, Final, Sp)

Like Ethan, Rose was in the position that spiritual care is not a priority in terms of a doctor’s role:

You know, if you’re a doctor who’s interested in spirituality and wants to talk about that with you patients, that’s cool. But every doctor needs to be competent in, in the physical, kind of, conditions that we treat. You know, we don’t treat sinfulness or lack of salvation, but, you know, we treat psychiatric and we treat medical conditions. (Rose, Final, Re)

4.3.6 Summary of Themes

This chapter provides a thematic overview covering: how spirituality is understood and how this understanding is developed; how spirituality and health could be related and the place of spirituality within healthcare delivery; the presence of spirituality in the medical school experience; the role of spirituality in the lives of medical students; and finally, students’ preferences on a curriculum around spirituality.
5 Discussion

In this section, the results of the interviews with medical students are discussed in relation to the literature with a focus on six areas: Understandings of Spirituality, Spirituality and Healthcare, Spirituality and Medical Students, Spirituality and Medical School Experience, First Year vs Final Year Medical Students, and Training Preferences. Following a critique of the study findings, the chapter describes the strengths and limitations of the study.

5.1 Understandings of Spirituality

Medical students in my study spoke of spirituality in a variety of ways. Majority of the students expressed that spirituality is a subjective term and that many meanings exist. The position that spirituality is broadly defined is well documented in literature (Egan, MacLeod et al. 2011, Egan, MacLeod et al. 2014). Some medical students also conveyed the sense that spirituality is difficult to define, and this reflects the lack of consistency in definitions in the field (Steinhauser, Fitchett et al. 2017). Most medical students started by mentioning the difference between spirituality and religion which reflects the trend that spirituality is nowadays understood as more than just religion (Egan, MacLeod et al. 2011, Weathers, McCarthy et al. 2016). Seven medical students in my study identified as ‘spiritual but not religious’, a label that has been increasingly reported in studies (Astrow, Wexler et al. 2007, Koenig 2012) which also supports the position that spirituality and religion are related but different constructs, and that religion is part of the bigger frame that is spirituality. A number of medical students were conscious of the cognitive aspect of spirituality. One student said, “it’s a thought process type of thing” (Talia, First, No). Students used descriptors such as “beliefs” or “believe”, which are commonly used descriptors (Egan, MacLeod et al. 2011, Stephenson and Berry 2015) and has been included in proposed definitions (National Cancer Institute, Speck, Higginson et al. 2004). Other researchers have similarly spoken of spirituality in this way. For example, Salsman et al. included “cognitive” as one of the dimensions of S/R (Salsman, Fitchett et al. 2015). Some medical students understood spirituality as a lens through which life and the world is seen and is heavily related to
“meaning”, a commonly used descriptor (Unruh, Versnel et al. 2002, Egan, MacLeod et al. 2011, Stephenson and Berry 2015, Weathers, McCarthy et al. 2016). Proposed definitions have similarly highlighted this perspective (National Cancer Institute, Puchalski, Vitillo et al. 2014). Spirituality manifesting in certain practices, traditions and in the way an individual relates to nature, people and arts has been previously described (Tanyi 2002, Speck, Higginson et al. 2004, Puchalski, Vitillo et al. 2014), and certainly, medical students in my study articulated a similar view. For participants in my study, appreciation for nature, self-care, self-awareness, and the way in which they connect with friends and family are some of the ways in which their spirituality manifests. The literature has identified an intangible component to spirituality, citing terms such as transcendence, connection, higher power or force and relationship (Unruh, Versnel et al. 2002, Speck, Higginson et al. 2004, Gall, Malette et al. 2011, Berghuijs, Pieper et al. 2013, Puchalski, Vitillo et al. 2014, Stephenson and Berry 2015, Weathers, McCarthy et al. 2016) which several medical students in my study have also articulated. As commonly referenced in the literature (Tanyi 2002, Speck, Higginson et al. 2004, Puchalski, Vitillo et al. 2014), medical students in my study also emphasized the possible outcomes of spirituality, which include hope, resilience, happiness and purpose. A number of students expressed spirituality as a source that helps them keep moving forward. It is clear that spirituality is a positive aspect for some.

The idea that religion and spirituality overlap indicated by medical students in my study has also been reported in previous research (Zinnbauer, Pargament et al. 1999). A number of students spoke of religion as giving structure to spirituality which reflects the literature that depicts religion as a sub-concept in the wider idea of spirituality (Sulmasy 1999, Swinton 2001, Sulmasy 2002, Speck, Higginson et al. 2004). The position that religion is one way of expressing spirituality is illustrated well by a religious student in my study. When asked how she understood spirituality, Lucy’s response was “I think, for me, it’s very much religion” (Lucy, Final, Re). However, later on she acknowledged that spirituality, as a whole, is a belief system and it is just that her spirituality is oriented around Muslim beliefs. Similarly, another student suggested that her spirituality links back to Buddhism principles. Also supporting the position that religion is one way of expressing spiritual, is the perception that religious people are inherently spiritual, as articulated by some medical students in my study.
Certainly, the majority of medical students in my study are cognisant of spirituality being more than just religion, as also reflected in previous research (Egan, MacLeod et al. 2011, Weathers, McCarthy et al. 2016).

There were two outlier responses about how medical students understand spirituality. The first one is a first-year student saying that “spirituality is the creative side to someone” (Henry, First, Sp). This is related to literature that describes spirituality being expressed through an individual’s relationship with music and the arts (Sulmasy 2002). The other outlier response was Harry’s view that spirituality is just a language that people use to describe elements of mental health. He said that healthcare professionals need to be aware of this way of describing mental health issues in the guise of spiritual issues. Upon initial analysis, Harry’s response seemed isolated to the others. However, following deeper consideration, his view reflects the well-documented position that spirituality is a subjective and often self-defined construct (Paloutzian 2014) which has resulted in many definitions of spirituality being generated (Moberg 2002, Miller and Thoresen 2003, Steinhauser, Fitchett et al. 2017). This subjective nature of spirituality extends to how the relationship between spirituality and health is perceived, as exhibited by many medical students in my study; the way they think spirituality affects their own health (or how it affects them when they are unwell) is heavily dependent on their own definition of spirituality. For example, a final-year medical student who used descriptors such as relationship and connection to define spirituality articulated that maintaining connections is a massive part of keeping herself spiritually well. Another student understood spirituality as a “search for meaning”. When describing the relationship between spirituality and health in his personal life, he frequently referred to his ability (and failure) to derive meaning from life events. While Harry sees spirituality as a “language” to describe mental health, other medical students use spirituality as a “language” to describe other elements of wellbeing. See Appendix J for a table that summarises this trend. It is important to note that even though many medical students illustrate the trend that how spirituality affects an individual’s health is related to how the individual defines spirituality, this did not apply to all of the medical students in my study.
A number of medical students in my study shared the view that everyone is spiritual “whether they realise it or not” (Iris, First, Sp). This view is consistent with Sulmasy’s as reported in his article that introduces biopsychosocial-spiritual model (Sulmasy 2002). This model assumes that everyone is spiritual. It is also reflected in a consensus-derived definition that says spirituality is an intrinsic part of humanity (Puchalski, Vitillo et al. 2014). It is important to note there is some criticism of this position, calling it a colonising approach (Hodge 2018).

Interviews with medical students in my study show that spirituality is dynamic and changes as a result of active exploration and exposure to different life experiences. A consensus-derived definition also depicts spirituality as dynamic (Puchalski, Vitillo et al. 2014). It also describes spirituality as an active process where “persons seek ultimate meaning, purpose, and transcendence”. Pargament and Zinnbauer also write about spirituality as being dynamic and experience-based (Paloutzian 2014).

5.2 Spirituality and Healthcare

As previously mentioned, medical students in my study were mindful of the potential outcomes spirituality could bring into an individual’s life. When asked how they thought spirituality could influence patients, a number of medical students conveyed the same view that spirituality could give patients the ability to cope, hope, strength, “something to lean on” as well as peace at the end of life. Previous studies have reported a similar appreciation (Pierce, Steiner et al. 2008, Vallurupalli, Lauderdale et al. 2012, Harbinson and Bell 2015, Hawthorne, Youngblut et al. 2016, Gattari, Arfken et al. 2018). One medical student in my study was cognisant of the potential harm a “shaken” belief in the afterlife could bring about. Brett said that it may lead to uncertainty and ease. Other researchers have similarly spoken of this potential harm and is reported as spiritual struggle in the literature (Pargament, Murray-Swank et al. 2005). The view that spirituality could affect mental health, cited by some medical students in my study, supports the findings from other studies (Pargament, Koenig et al. 2001, Kattan and Talwar 2013, Salsman, Pustejovsky et al. 2015). One medical student in my study explained why he thought mental health and spirituality were linked. He suggested that spirituality is the product of human consciousness, which means that different
states of consciousness will affect S/R levels. He gave the example of a patient with schizophrenia, saying, “when they’re having an episode, it’s going to be hard to be a spiritual person”.

Other possible influences of S/R on patients include its effect on medical decision making, health behaviours and self-perceived experience of their illness. As identified in previous research (Ai, Park et al. 2008, Jaul, Zabari et al. 2014, Arutyunyan, Odetola et al. 2018), some medical students were mindful of how S/R beliefs could affect medical decision making such as whether or not patients would be open to certain treatments. Three medical students in my study were conscious of how spirituality could influence health behaviours, such as how one nourishes their body and how an individual’s spirituality could give them a reason to live a healthier life. This has also been previously described in the literature (Davis, Worthington et al. 2014, Hook, Worthington et al. 2014). One medical student in my study articulated that a patient’s spirituality could affect how much pain they perceive themselves to be in, which in turn could lead to a physiological response. Wachholtz et al. posed a similar claim in that an individual’s S/R has an effect on their pain tolerance (Wachholtz, Pearce et al. 2007). This position was also noted in the review article by Siddall et al. (Siddall, Lovell et al. 2015).

The role of the doctor in the integration of spirituality and healthcare was explored in my study. One medical student in my study expressed how spirituality cannot be entirely removed from wellbeing. She followed on by explaining that the doctor’s role is attend to the wellbeing of the patient, and because spirituality is intrinsically part of that, spirituality is an important part of the doctor’s role. This position is related to Durie’s Māori health model that depicts spirituality as an inherent cornerstone of health (Durie 1998). Other studies have also noted that physicians are receptive to the inclusion of spirituality in healthcare (McCord, Gilchrist et al. 2004, Saguil, Fitzpatrick et al. 2011, Kattan and Talwar 2013, McGovern, McMahon et al. 2017, Gattari, Arfken et al. 2018). A number of medical students in my study spoke favourably of acting as someone who identifies patients’ S/R needs and then referring to appropriate services accordingly. This view has also been reported by other researchers (Handzo and Koenig 2004, Best, Butow et al. 2016, Saad, de
Medeiros et al. 2017). Medical students in my study preferred to leave it to experts such as chaplains when it comes to attending to patients’ spiritual needs. In support of this, patients from a hospice study said that they did not expect doctors to be spiritual experts and only wanted respect from doctors about their S/R beliefs (Hart, Kohlwes et al. 2003). Reasons cited by medical students in my study for wanting to refer to spiritual services include moral obligations such as avoiding doing harm to a patient by recognizing the limits of their abilities. One medical student said that the doctor’s role is providing the best care possible and this includes making referrals to a chaplain or religious advisor if indicated. This collective acknowledgment by the medical students in my study around patient S/R and its role in healthcare is in line with holistic approaches such as the biopsychosocial-spiritual model (Sulmasy 2002). One student, Rose, mentioned how doctors need to be skilled in the sense that they should realise that making a referral to spiritual services is not always necessary. Rose said how sometimes, “they just need a listening ear for five minutes” which suggests that sometimes, patients only need a doctor’s presence and not a full spiritual intervention. This practice of presence and listening has been reported to be part of spiritual care (Anandarajah and Hight 2001). Some doctors also “indirectly” provide spiritual care by actively listening to their patients and being present with them, as reported by previous research (Vermandere, De Lepeleire et al. 2011).

Medical students in my study conveyed the potential effects of integrating spirituality into healthcare. One student recounted her experience in her hospice and palliative care attachment. She said that when the healthcare team attended to patients’ spiritual needs, it often resulted in a greater sense of hope and ability to cope. She also shared her observation about the resulting increased engagement from the patients with the healthcare team when patient and family spirituality was acknowledged. Another student in my study articulated the potential effect of patients feeling like doctors care more if patient spirituality is considered. Previous research has reported similar effects of SC such as improving the doctor-patient relationship (Phelps, Lauderdale et al. 2012) and increasing the trust patients have on their doctor (Phelps, Lauderdale et al. 2012). Medical students in my study also expressed concern about the effects of ignoring patient spirituality. As revealed in the interviews, neglecting patient spirituality increases the risk of creating another barrier
between the patient and the doctor. This finding is relevant to previous research which states that the most important reason for discussing S/R was desire for physician-patient understanding (McCord, Gilchrist et al. 2004). Another student highlighted the importance of approaching S/R issues in a non-judgmental manner to facilitate treatment compliance and understanding between the doctor and the patient. Patients in a qualitative study similarly viewed a non-judgemental approach as important when it comes to discussing S/R in the healthcare context (Ellis and Campbell 2004). A previous study also reported on the effects of SC on treatment compliance (Gattari, Arfken et al. 2018). Approaching S/R issues in a non-judgemental manner is relevant to a recognised component of SC that is patient-centred care. A patient-centred approach supports patients in their worldview, which can be influenced by patient S/R (Puchalski, McSherry et al. 2010), allowing them to set the agenda. Certainly, medical students in my study share this acknowledgement of the importance of focusing on what matters to the patient as what might be irrelevant for one patient may be very important to another. One student specifically criticised how hospitals are designed to be more convenient for doctors and not patients, expressing that the healthcare system needs to do more than just lip service when it comes to patient-centred care. Advocacy for patient-centred care has also been recorded in literature (Edwards, Pang et al. 2010).

Medical students in my study were asked if they would feel comfortable addressing spirituality in patient interactions. It is apparent that whether or not they are spiritual, religious or neither, most students in my study are happy to address patient S/R. This reflects previous research that reports healthcare professionals being receptive to incorporating S/R into healthcare (McCord, Gilchrist et al. 2004, Saguil, Fitzpatrick et al. 2011, Kattan and Talwar 2013, Austin, Macleod et al. 2017, McGovern, McMahon et al. 2017, Gattari, Arfken et al. 2018). However, other medical students were cognisant of their current lack of knowledge in the area and said that they are not comfortable right now but will be once they learn more about the topic. The lack of S/R knowledge as a barrier to SC has also been recorded in previous research (Egan, MacLeod et al. 2014, Austin, Macleod et al. 2017).

The contextual appropriateness of spiritual care has been discussed in both the interviews in my study and in the literature. Some medical students in my study shared the sentiment that
there is the right time, place and patient for spiritual care. For example, some thought that spiritual care is more fitting in the hospital than in a fifteen-minute GP consultation. However, one student disagreed with this and expressed that the hospital environment is too busy for addressing S/R issues, citing that a GP situation would be more appropriate. Lack of time for SC in both the hospital setting and GP setting have been reported in previous research (McBrien 2010, Vermandere, De Lepeleire et al. 2011). Medical students in my study were also mindful of certain patients that SC would be more relevant for, such as those who are religious, have a serious illness or in palliative care. One student, Reece, explained why he thought palliative care scenarios are suitable for SC. He said that in these situations, patients and those around them are experiencing an extremely trying time, both physically and emotionally. The view that the severity of a patient’s illness is related to how appropriate SC is has also been proposed in previous research (McCord, Gilchrist et al. 2004, Luckhaupt, Yi et al. 2005, Best, Butow et al. 2016, Arutyunyan, Odetola et al. 2018). Previous studies also share a similar appreciation for the effect patient and family S/R has on how receptive they are to SC (Phelps, Lauderdale et al. 2012, Arutyunyan, Odetola et al. 2018). One student in my study emphasised the importance of “picking your moments” and how S/R discussion should be patient-led. However, another student said that she would rather lead and initiate S/R discussions, reflecting her concerns of patients “missing out”. The literature has also explored a similar discussion around who should initiate S/R discussions (Ellis and Campbell 2004, McGovern, McMahon et al. 2017).

Medical students in my study were mindful of the resource constraints currently present in the healthcare system. They expressed concern of SC taking more effort and time, which is challenging in a system that is already pushed for resources and staffing. Another medical student, Ethan, described the culture of discharging patients who are “good enough to go home” to make available bed space for incoming patients, despite the fact that the medical team could have done “so much more” for the patients. The lack of time and resources being a barrier to SC has also been documented in the literature (Balboni, Sullivan et al. 2014, Egan, MacLeod et al. 2014, Best, Butow et al. 2016, Gattari, Arfken et al. 2018).
Other factors that seemed to affect receptivity towards S/R among medical students in my study included the lack of self-awareness and the view that S/R is a personal topic. Among the respondents in my Recruitment Form, some students said that they were not interested in participating in my study because they were not self-aware enough in their own spirituality or were not interested enough in the topic to have anything to contribute. Lack of physician spiritual awareness as a barrier to SC has also been explored in previous research (Ellis and Campbell 2005). One student in my study said in their interview that S/R is a personal topic. When providing a reason of why they were not interested in participating in my study, one student said they were not comfortable answering questions concerning spirituality. Interestingly enough, these two students were both religious. Another student, who identified as ‘spiritual but not religious’, who was not interested in being interviewed, expressed concern about the potential of their family situation coming up in the interview. They said they were not comfortable enough yet to talk about it which is why they decided not to take part in the interview. S/R being too personal (Gattari, Arfken et al. 2018) to be part of discussions with the doctor and causing discomfort (Ellis and Campbell 2004, Ellis and Campbell 2005) has previously been cited as barriers to SC (Gattari, Arfken et al. 2018).

5.3 Spirituality and Medical School Experience

Medical students in my study were asked about what teaching they had received on the topic of spirituality and healthcare. Some students indicated that they received explicit teaching on spirituality in relation to Māori health and Pacific health. One student spoke favourably of the Māori department, and expressed that they do very well in teaching students to think of the patient context. The inclusion of Māori and Pacific perspectives around spirituality is in line with recommendations in the literature around considering ethnicity and culture when developing curricula with S/R (Memaryan, Rassouli et al. 2015, Lucchetti, Ramakrishnan et al. 2016). Another student described learning about how people can be spiritual in both religious and non-religious ways. Teaching delivered on spirituality in the undergraduate medical curriculum from the medical students’ perspectives has not been explored much. However, the literature has reported on courses including content on: spiritual history taking,
It is apparent that there is some teaching on spirituality in the Otago medical curriculum, as indicated by medical students in my study, but explicit teaching on practical ways of integrating spirituality into healthcare has not been described. Some medical students in my study reported that on their rest home placement, they were required to inquire about residents’ spirituality. Final year medical students also mentioned “organic learning” as opposed to explicit teaching. Organic learning included witnessing doctors in the hospital working with chaplains, priests and kaumatua. When asked if they had received teaching on spirituality, some of the participants in my study expressed that direct teaching was absent, but that they were taught about related topics. It is interesting to observe what they thought to be related to spirituality, as it reveals further their conceptual understanding of spirituality. The topics mentioned being related to spirituality included: student wellbeing, reflection, respect for patients, ethics, professional development, tikanga practices and cultural competence. A few medical students in my study said that they were unsure or cannot remember if they had received teaching and some students said they had received no teaching. It is also important to note that a few medical students in my study were content with the amount of spirituality teaching included in the curriculum. Overall, it seems that there are varying views among medicals students in my study about the teaching they have received on spirituality while in medical school. Interestingly, a NZ study with those involved in medical school curriculum development and delivery (Lambie, Egan et al. 2014) revealed that staff also had different views of how much teaching on spirituality is in the curriculum. When asked where spirituality was in the curriculum, respondents had the following replies: “probably comes up occasionally”; “touched on” alongside a number of different subjects; unsure; not taught. These responses are similar to that of the medical students in my study.

Some medical students in my study shared their experiences while in medical school where the topic of spirituality was relevant. It is apparent that learning as experienced by medical students is variable in nature due to being exposed to different clinical scenarios, an idea I
have assigned the term “opportunistic learning” in my study. Opportunistic learning regarding spirituality, as shared by medical students in my study, arose from interviews with patients, experiences with religious patients while on elective, and witnessing healthcare teams acknowledge patient S/R. This idea of learning as relevant issues emerge in the care of particular patients was also acknowledged by those involved in NZ medical curriculum development and delivery (Lambie, Egan et al. 2014).

A number of medical students in my study spoke of changes with their attitudes and knowledge relating to S/R as a result of their medical school experience. The impact medical school has had relevant to S/R as suggested by medical students in my study included: a broader understanding of S/R as a whole; an increased awareness on the positive and negative aspects of S/R in patients; and an increased understanding of personal S/R. Other studies share a similar appreciation of the potential positive effects of S/R teaching (Lucchetti, Lucchetti et al. 2012) such as increased awareness (Kattan and Talwar 2013) and increased appreciation (McGovern, McMahon et al. 2017).

Some medical students talked about medical school experiences that negatively affected them. One medical student in my study talked about how being in his rest home placement and witnessing people deteriorate “stripped away” at his spirituality. Another student shared their view about having less chances to reflect on her own spirituality as she progressed through medical school because of time constraints within the hospital. This is in line with previous research that reported S/R as a factor that influences how medical students navigate through medical school (Ray and Wyatt 2018).

5.4 Spirituality and Medical Students

For medical students in my study, except for two, spirituality played a role in their personal lives to varying levels. As medical students responded to questions about the link between their S/R and health, it is apparent that spirituality plays a cognitive role for most of the students. This cognitive role came in the form of framing and reframing situations. As revealed in the interviews, spirituality helped most students reframe times of stress through seeing the “bigger picture” which allowed them to “keep moving forward”. Other studies
have similarly highlighted the role spirituality has on medical students in framing challenges in order to cognitively process them (Ray and Wyatt 2018), and hope and optimism for the future (Krageloh, Henning et al. 2015). With the responses from medical students in my study, it is also suggested that spirituality manifests in certain behaviours that assists them with coping such as reflection, attending religious support groups, prayer, going out into nature, connecting with other people and mindfulness. Previous research has similarly described the cognitive and behavioural dimensions of spirituality (Salsman, Fitchett et al. 2015). Furthermore, a few medical students in my study spoke of the behavioural and cognitive aspects of spirituality affecting their mental health. The link between spirituality and mental health is well documented in the literature (Pargament, Koenig et al. 2001, Salsman, Pustejovsky et al. 2015).

When asked how they keep themselves well, some students explained how spirituality affected their health, and others explained how they kept themselves spiritually healthy. It seems like some participants explained spirituality as an external factor that affects health, and others talked about spirituality as an intrinsic dimension of health. It is also important to consider that some students seem to describe spirituality in both ways. However, this could just reflect the commonly cited position that spirituality is a difficult concept to grasp reflected in existence of many definitions (Moberg 2002, Miller and Thoresen 2003, Puchalski, Vitillo et al. 2014, Steinhauser, Fitchett et al. 2017). Responses in my study that alluded to spirituality being an intrinsic dimension of health supports health models such as the biopsychosocial-spiritual model (Sulmasy 2002) and Te Whare Tapa Whā (Durie 1998) that assumes everyone is spiritual. However, it is important to consider that some people think negatively of spirituality (Berghuijs, Pieper et al. 2013) and that not everyone identifies as spiritual or religious, as found in my study.

Medical students in my study spoke of their spirituality as a source of moral guidance and a source of positive feelings. In terms of moral guidance, their spirituality had an effect on their health behaviours, how they treat other people and how to position themselves in social justice issues. Other studies have also cited the role S/R has in people’s ethics, morals, health behaviours and decision making (Davis, Worthington et al. 2014, Hook, Worthington et al.
In terms of positive feelings, medical students in my study spoke of: awe; “feeling better”, “good feeling”, “freeing”. The connection between spirituality and positive feelings has been described before (Vaillant 2008).

Some medical students in my study conveyed the sense that they need the right conditions to foster their spirituality. One student talked about journaling on Sundays and praying just before bed because it worked best for her. Another student said that it is easier to be spiritual when he is happy. Doubts about the school’s intentions related to spiritual growth was expressed by one student in my study. She said how the medical school encourages self-care, a component of her spirituality, but at the same time medical school makes it difficult to practice self-care because of the amount of content and contact time. Another student described putting his spirituality on pause because of how demanding medical school is, but that he plans on taking a year off to delve into spirituality deeper. Medical students in another study similarly expressed needing the right conditions for their spiritual side and that they intend to set time aside for it (Ray and Wyatt 2018).

A few medical students in my study also grappled with reconciling their own spirituality with their professional identity as a medical student. For one religious medical student, she spoke of having difficult experiences when she encountered situations related to abortion. Difficulty with contentious subjects such as abortion in relation to student spirituality was also acknowledged in another study (Ray and Wyatt 2018). Another student recalled thinking about how he could keep his religious identity intact without compromising the doctor-patient relationship. Previous research has similarly reported this balancing act as related to student spirituality (Ray and Wyatt 2018). Additionally, teaching on the integration of S/R into professional identity and S/R related to controversial social issues has been previously recommended to be included in medical curriculum (Mitchell, Epstein-Peterson et al. 2016).

Two religious medical students in my study indicated that their spirituality influences their attitudes towards health issues. One student talked about how she finds her faith and medicine as complementary and how she would still access treatment if she fell ill. Another student shared her thoughts about resuscitation and how she is against it for herself because
she believed that there is something promising after death. Other researchers have similarly described S/R affecting medical decision-making role (Ai, Park et al. 2008, Jaul, Zabari et al. 2014, Arutyunyan, Odetola et al. 2018).

5.5 Training Preferences

When asked what they would prefer to be taught about in terms of spirituality and health, medical students in my study outlined what their desired outcomes and content are for a spirituality course in medicine. Their desired outcomes included: to improve student wellbeing; to know how to avoid doing the wrong thing; to be more confident; to improve awareness. In terms of content, medical students in my study wanted to learn more about spirituality as a concept, spirituality and its relationship with health, as well as spirituality and its place in healthcare. Studies have similarly reported on the appeal of including both personal physician S/R growth and S/R as related to patients and healthcare in medical curricula (Kattan and Talwar 2013, Harbinson and Bell 2015, Memaryan, Rassouli et al. 2015, Mitchell, Epstein-Peterson et al. 2016, Geer, Visser et al. 2017, McGovern, McMahon et al. 2017).

Medical students in my study shared their preferences around format of spirituality teaching. It is apparent that most participants would appreciate an interactive platform like small-group tutorials. One student talked about wanting to learn directly from patients through storytelling. Another student, who was cognisant of lecture slot constraints, proposed an event format similar to their Pacific Immersion Day. Another student talked about wanting to receive input from older medical students about the importance of spirituality as they experience it in the hospitals. Previous research has similarly noted the preference towards small group teaching (Tang, White et al. 2002, Harbinson and Bell 2015), learning through patients’ personal stories and through physicians’ personal experiences with spiritual issues in patient care (Tang, White et al. 2002). Medical students in my study also proposed continuous exposure on the topic which supports another study that recommends longitudinal learning on S/R (Mitchell, Epstein-Peterson et al. 2016).
Even though all of them acknowledged the importance of receiving teaching on spirituality, medical students in my study held a slightly dismissive tone towards the topic. Previous research has also acknowledged the diversity of perspectives on spirituality among the medical student population (Lambie, Egan et al. 2014). Descriptors such as “fluffy”, “airy fairy”, “wishy-washy”, “stoner talk” and “cheesy” were used by medical students in my study when talking about spirituality. Interestingly, medical students who used these descriptors considered themselves to be spiritual. These descriptors reflect the view that medical students are scientific-minded, as expressed by medical students in my study. One student proposed that presenting evidence from research about the importance of spirituality would perhaps be appealing and an effective way of teaching the topic to scientifically-minded medical students. When deciding whether spirituality teaching should be compulsory or optional, medical students in my study considered this perceived common trait among medical students. The tension between knowing about the importance of spirituality in healthcare and students being geared towards more “scientific” topics is evident in the mixed opinions about whether spirituality teaching should be compulsory or optional. Other studies similarly report mixed opinions (Harbinson and Bell 2015, Mitchell, Epstein-Peterson et al. 2016).

One religious medical student in my study conveyed slight hesitation towards the inclusion of spirituality in the medical curriculum because of its personal nature. She recounted an experience where students, while in a tutorial, where dismissive about the spiritual nature of Alcoholics Anonymous which was offensive to her. She said she did not want other students to be harmed in this way. Previous research has similarly acknowledged the sensitive and personal nature of spirituality being a barrier (Lambie, Egan et al. 2014, Gattari, Arfken et al. 2018).

5.6 First Year vs Final Year Medical Students

In terms of conceptual understandings of spirituality, there were varying levels of knowledge in both groups of medical students in my study. Some students in both groups expressed difficulty in defining the concept. Equally, some students in both groups were able to
articulate thoroughly their understanding of spirituality. What seemed to be related to how well students were able to explain their understanding of spirituality was not what year group they were in but more so how much active exploration students had undertaken. I assumed that final year medical students would be markedly more informed on the concept of spirituality as a result of having more learning opportunities on spirituality. However, it is apparent that there is very little explicit spirituality teaching in the Otago curriculum, as expressed by many students in my study. Therefore, the lack of difference in the level of understanding between first and final year medical students could be because there is little presence of the topic in the curriculum in the first place. As well, the small sample size limits proper comparison between both year groups.

In terms of receptivity towards the inclusion of spirituality in healthcare and medical education, there were no obvious differences between first and final year medical students in my study. However, final year medical students conveyed the opinion that as medical students progress through medical school and are exposed to more patient interactions, they will be more able to appreciate the role of spirituality in healthcare. In terms of acknowledgement and receptivity towards spirituality, there are no marked differences, but it seems that final year medical students in my study have a deeper appreciation of spirituality in healthcare. It has been previously reported that training in SC results in increased appreciation of S/R in the holistic care of patients (McGovern, McMahon et al. 2017). Again, it is important to consider that the small sample size limits proper comparison between both year groups.

5.7 Strengths and Limitations

Given the amount of people who identify as having no religion in NZ is increasing, religious affiliation decreasing and the acknowledgement of “spiritual but not religious” in NZ literature, this project tried to capture NZ’s diversity in spiritualties in a sample of medical students. The sample is dominated by those who identify as “spiritual but not religious” and those who are neither religious or spiritual, with only three medical students who self-identified as religious. A strength of the study strength was the inclusion of five students...
who identified as Māori. A further strength was the proportional representation of students who entered medicine through the three different pathways. The fact that many students were interested in participating allowed me to pick which students to follow up for an interview, allowing maximum variation in the sample. To my knowledge, this project appears to be the first in NZ to explore medical students’ views on spirituality and its role in health, healthcare and medical education.

Another strength of this study is the primary investigator (MCD) is a medical student that could relate to the medical students’ perspectives due to similarities in medical school experience. This not only allowed for a greater understanding of the perspectives discussed, but also allowed rapport to be built with the participants. Additionally, I held the position of Vice President for the Otago Medical Students’ Association at the time. It may be that this position could have affected how open or comfortable students were in the interviews. This insider position was a strength.

One of the primary limitations of the study was that interviews tended to be weighted more towards how students understood the concept of spirituality and their spiritual journey even though the interview schedule showed a balance across the different domains. This imbalance most likely reflects my personal interest in those domains at the period of data collection. Another limitation was the selection of medical students. Even though students were randomly selected, the project relied on students responding. There is potential that students with particularly positive or negative views about spirituality may have been more inclined to participate in the project. This is reflected by the trend in my study that students were either very articulate in explaining their spirituality or had a rich spiritual history, or plainly atheist. Another limitation is the small sample, which means that this study’s findings cannot be generalised. A further limitation is to do with the teaching received around spirituality. Because the results were self-reported, the teaching delivered might be different to what was actually experienced. An exploration of the medical curriculum by talking to those involved in curriculum development and delivery to produce confirmatory data was initially planned. However, time did not allow for this to happen and it is reported elsewhere (Lambie, Egan et al. 2014).
Finally, as with all qualitative research, the beliefs and values of the researcher will inevitably influence all stages of the project. With this in mind, I have attempted to be transparent about my background in the Methodology chapter and I was careful, working with my supervisors, to reflect on my own positions and bias over the year of the study.
6 Final Summary

This thesis explored the overarching question, ‘How do Otago medical students perceive spirituality and its role in healthcare?’ To answer this question, the following were also investigated: Otago medical students’ conceptual understanding of spirituality, spirituality and health, and spirituality in medical education. Within the limitations noted above, the following conclusions can be drawn from this research project:

- Among Otago medical students, spirituality is understood in a variety of ways. How they understand spirituality is influenced by family, culture, school, friends and active exploration.
- Otago medical students acknowledge that spirituality and religion are related, but different constructs.
- Spirituality plays a role in the health and wellbeing of some Otago medical students, specifically around stress management. However, it is important to note that how medical students perceived the role spirituality has on their own health seemed to be based on their definition of spirituality.
- Otago medical students acknowledge that spirituality could be important for patients and are somewhat aware of how it could be a positive or negative aspect of patients’ lives. Otago medical students understand the effect spirituality has on patients’ health behaviours, medical decision making and interpretation of their illness journey.
- Otago medical students recognise the importance of patient-centred spiritual care and its potential to positively affect patient satisfaction and the doctor-patient relationship. However, they are aware that spiritual care could be resource intensive.
- Otago medical students acknowledge the doctor’s role in identifying spiritual distress in patients and making referrals to spiritual services accordingly.
- Otago medical students receive little formal teaching on spirituality. The most cited and most appreciated learning has been around Māori health and spirituality. No teaching on incorporating spirituality in health assessment and healthcare delivery was reported.
There is substantial receptivity among Otago medical students towards more spirituality teaching, specifically around spirituality as relevant to patients and healthcare delivery, as well as student wellbeing.

Otago medical students prefer an interactive platform for leaning about spirituality. However, there are mixed views on whether or not spirituality learning should be compulsory or optional.

Otago medical students have an inclination towards scientific and evidence-based topics. Development of a curriculum including spirituality should take this into account.

There are no obvious differences between first and final year Otago medical students regarding the level of understanding on spirituality as a concept. In terms of acknowledgement and receptivity towards spirituality, there are no marked differences between the year groups, but it seems that final year medical students have a deeper appreciation of spirituality in healthcare, which some attributed to more patient exposure.

Overall, Otago medical students acknowledge the place spirituality has in healthcare. However, they lack depth of understanding which is likely to be a result of the little formal teaching they have received on spirituality. Further work should focus on improving Otago medical students’ competency around spirituality and healthcare to meet the increasing demand for spiritual care. Additionally, there is indication that spirituality influences stress management in this cohort of young people as it plays a role in reframing situations so that they can cognitively process them. Further work should explore spirituality as a tool for young people to navigate stressful experiences.
7 References


Harbinson, M. T. and D. Bell (2015). "How should teaching on whole person medicine, including spiritual issues, be delivered in the undergraduate medical curriculum in the United Kingdom?" *BMC Medical Education* **15**(1).


approach to examining the correlation between religion/spirituality and mental health in cancer." Cancer 121(21): 3769-3778.


8 Appendix A - Ethics Approval

Dr R Egan
Department of Preventive and Social Medicine
Dunedin School of Medicine
University of Otago Medical School

23 May 2018

Dear Dr Egan,

I am writing to let you know that the Ethics Committee has now considered under the ‘Fast-Track’ provisions your proposal entitled ‘Otago medical students’ perspectives on spirituality and its role in healthcare’.

As a result of that consideration, the current status of your proposal is:- Approved

For your future reference, the Ethics Committee’s reference code for this project is:- F18/005.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Upon approval, it is expected that all members of the research team are made aware of what the standard conditions of ethical approval covers. This includes the date ethical approval expires, as well as the process regarding applying for amendments to the research.

The Human Ethics Committee asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page

http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html
Yours sincerely,

[Signature]

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8236
Email: gary.witte@ctago.ac.nz

c.c. Assoc. Prof. P Priest, Department of Preventive and Social Medicine
9 Appendix B - Māori Consultation

Tuesday, 08 May 2018.

Dr Richard Egan,
Dunedin School of Medicine - Preventive and Social Medicine,
18 Fredrick Street,
Dunedin,
9054.

Tēnā Koe Dr Richard Egan,

Otago medical students’ perspectives on spirituality and its role in healthcare

The Ngāi Tahu Research Consultation Committee (the committee) met on Tuesday, 08 May 2018 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University. In the statement of principles of the memorandum it states “Ngāi Tahu acknowledges that the consultation process outlined in this policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago”. As such, this response is not “approval” or “mandate” for the research, rather it is a mandated response from a Ngāi Tahu appointed committee. This process is part of a number of requirements for researchers to undertake and does not cover other issues relating to ethics, including methodology they are separate requirements with other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Māori, the Committee based consultation on that defined by Justice McGechan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The Committee considers the research to be of interest and importance.

As this study involves human participants, the Committee strongly encourage that ethnicity data be collected as part of the research project as a right to express their self-identity. That is the questions on self-identified ethnicity and descent, these questions are contained in the latest census.

The Committee suggests dissemination of the research findings to the Office of Māori Development, University of Otago.
We wish you every success in your research and the committee also requests a copy of the research findings.

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 08 May 2018 to 8 November 2019.

Nāhaku noa, nā

Mark Brunton  
Kaīwhakahaere Rangahau Māori  
Research Manager Māori  
Research Division  
Te Whare Wānanga o Otago  
Ph: +64 3 479 8738  
Email: mark.brunton@otago.ac.nz  
Web: www.otago.ac.nz
Appendix C - Student Access Request

22 Nov 2007 Joy R Rudland and John Dockerty

Policy regarding collection of Student Data for Research purposes

The Otago Medical School (OMS) has no concern in principle about requests to contact undergraduate medical students to participate in research into aspects of their education.

However, we do ask that researchers work through the OMS office in the first instance so we can ensure that students are not going to be overloaded or involved in research we consider inappropriate or of poor quality. We reserve the right to decline researchers the use of University channels to contact our students.

Otago Medical School Research Summary Form

Please complete this form (typed, not hand written) if you are conducting research that uses Medical Undergraduate Students in any of the four schools of the OMS (University of Otago, Wellington, University of Otago, Christchurch, Dunedin School of Medicine, School of Biomedical Sciences). Save it electronically as a MS Word document (please do not save it as a PDF) and please send to kelby.smith-han@otago.ac.nz. Please complete all 18 questions, and send at least 4 weeks prior to data collection. It is anticipated that this form will be returned to you within 5 working days.

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| 4. Aims of the research | - To explore conceptual understandings of spirituality and its role in healthcare in the literature through a literature review.  
- To explore conceptual understandings of spirituality and its role in healthcare among new and graduating Otago medical students, and to compare the findings between both year groups.  
- To explore current teaching about spirituality and its potential role in health assessment and delivery of health care at the Otago medical school. |
| 5. Group studied (class, year and location) | 2nd-year and 6th-year medical students in Dunedin |
| 6. Percentage of group to be | 3% of 2nd-year medical students (n=10) |
22 Nov 2007 Joy R Rudland and John Dockerty

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<td>Face/face semi-structured, one on one interview</td>
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**Maori Consultation**

11. If the research is conducted by a University of Otago member of staff, the following consultation process should be completed http://cupolicy.otago.ac.nz/maoriconsultation/index.html
Maori Consultation achieved

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If no consultation please explain: I am re-submitting my proposal to the Research Advisory Committee (RAC) of the Department of Preventive and Social Medicine next month. I will wait for their response before I seek Māori consultation.

**Ethics approval and impact factors**

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| 13. The impact on students (e.g. potential for harm, intrusive) | Some questions are personal as topics include spirituality and religion. |
| 14. How much time will students be required to input? | 1-hour interview |
| 15. Any culturally sensitive issues? | Yes. The questions will include topics such as spirituality and religion. |
| 16. What impact may this research have on the curriculum? | This project aims to provide a map of spirituality in healthcare teaching within the Otago Medical School curriculum. The results will be used to make a report addressed to the Otago Medical School which could be used as a resource to help guide curriculum development. |

**Support and feedback to students**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Are you requesting any assistance with logistics? If yes by whom and what? (e.g. e-mail distribution list)</td>
<td>Staff member name: (Staff member must have agreed to provide assistance)</td>
</tr>
<tr>
<td>Support required: I am wanting to undertake a purposive sampling approach. As the RAC suggested, this approach will help capture a fuller understanding</td>
<td></td>
</tr>
</tbody>
</table>

2 OMS November 2015
as there is considerable heterogeneity among medical students. Hence, it would be helpful to have details such as Ethnicity, Gender, Birthday, Citizenship/Residency Status, Entry Pathway and Disability information from the two groups. Sampling will be based on these categories and we will need help with emailing students.

18. Is the option given for students to receive results and if yes how?  

We will offer a summary of the results to the participants.

**18. Any other details you would like to include**

Supervisors:

Dr Richard Egan  
Department of Preventive and Social Medicine  
Email: richard.egan@otago.ac.nz  
Cell: 027 681 9370

Dr Hamish Wilson  
Department of General Practice and Rural Health  
Email: hamish.wilson@otago.ac.nz  
Cell: 021 267 6994

Dr. Kelby Smith-Han  
Medical Education Research Academic Lead  
Otago Medical School  
University of Otago  
NEW ZEALAND

**Official Use**

<table>
<thead>
<tr>
<th>Permission status awarded</th>
<th>Pending</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of outcome</td>
<td>2nd March, 2018 – notified by email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date form returned to researcher</td>
<td>17th April, 2018 – formal confirmation document emailed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Comments: We wish you well in your research project and BMedSc year!</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11 Appendix D – OMS Administration Support

Dr Richard Egan
Cancer Society Social & Behavioural Research Unit
Department of Preventive and Social Medicine
Otago Medical School

18 April 2018

Dear Richard,

Re emailing students invitations on behalf of Mary Cane Demecillo

Mary Cane Demecillo has requested that the OMS office email an invitation to partake in her BMedSc (Hons) research to 150 randomly-selected students from each of the ELM2 and 150 randomly-selected DSM, UOW, and UOC ALM6/Trainee Interns.

We have agreed to undertake this task: students will be sent individual emails from my role-based University email account: neither Mary Cane nor the participants will know the identity of all those sent an invitation. Mary Cane will provide me with a list of student IDs from responders so that I may email non-responders a maximum of two reminder emails.

Should you have any questions concerning this undertaking, please do not hesitate to contact me.

best regards,

Fiona Hyland
MB ChB Assessment Manager
Appendix E – Recruitment Email

Subject Line: Spirituality and Health: a plea for help from a fellow medical student undertaking research

Occasionally OMS assist BMedSci students by sending out emails (such as the one below) to students on their behalf. This protects the recipient’s (i.e. your) privacy, as your identity and email are not shared with the student. Should you wish to withdraw from this study, just let me know.

“The doctor of the 21st century will be both a highly skilled diagnostician and technician and a compassionate caregiver who respects all dimensions of patients’ life.” (Dr. Christine Puchalski, a pioneer and international leader in the movement to integrate spirituality and health)

Dear [Student’s First Name],

You have been randomly selected to take part in a study called “Otago Medical Students’ Perspectives on Spirituality and its Role in Healthcare”.

The purpose of this project is to explore what Otago medical students like you understand, based on your personal experiences and medical school teaching, about spirituality, and how spirituality is linked to your own health, patients’ health and healthcare delivery.

Please read the ‘Information Sheet’ below carefully before deciding whether or not to participate. Please record your response (interested/not interested) via the Response Form which is linked later in this email. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

Informed consent to participate is based on your reading of the ‘Information Sheet’ below, stating you are interested through the Response Form and agreeing to be interviewed.

Response Form:

Please record your interest or non-interest here.

Or copy and paste the URL below into your internet browser:
https://redcap.otago.ac.nz/surveys/?s=ED39R9TLYR

If you experience any difficulties accessing the Response Form, please contact us at demma386@student.otago.ac.nz

I hope you find time to participate in this study, as there is real value in the insights and information you can provide.

Yours sincerely,

Mary Cane Demecillo

-----------------------------------------------------------------------------------------------------------------------

Academic Committees, Room G22 or G26, Ground Floor, Clocktower Building,

University of Otago, Dunedin

Reference Number: F18/005

04 July 2018

OTAGO MEDICAL STUDENTS’ PERSPECTIVES ON SPIRITUALITY AND ITS ROLE IN HEALTHCARE

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

This project aims to explore what new and graduating Otago medical students understand about spirituality, and how spirituality is linked to their own health, patients' health and healthcare delivery. This project will provide a resource for the identification of knowledge gaps about spirituality in this population of Otago medical students which can be used to guide curriculum development. Additionally, the majority of Otago medical students are young adults. Therefore, gaining an understanding about their attitudes regarding the role of spirituality in their own health could serve as a stepping stone for integrating spiritual care in specialties where the health of young adults is a focus. This project is being undertaken as part of the requirements for Mary Cane Demecillo’s Degree of Bachelor of Medical Science with Honours.
What Type of Participants are being sought?

A random sample of 2nd-year and 6th-year medical students will be invited to take part by email. A reminder email to non-responders will be sent as well. Students are to record their response (interested/not interested) via an online Response Form. This form also asks the students to provide their Student ID, gender, date of birth, citizenship, ethnicity, religion, and entry pathway. Non-interested students are asked to provide a brief explanation about why they do not want to participate. The primary investigator will answer any questions the potential participant may have.

For interested students, by completing the online response form, you are affirming that you have read and understood this Information Sheet and therefore consent to participate in this project.

Ten students from those who express interest from each year group will be selected to participate in the study. Students will be given a $10 New World Voucher as a thank you for their participation. A copy of their transcript and summary of the results will be offered to the participants at the completion of the study.

What will Participants be Asked to Do?

Should you agree to take part in this project, you will be asked to

- Complete a one-on-one, face-to-face or Zoom semi-structured interview with the primary investigator (student researcher). This will take approximately 1 hour.
- The topics covered will include spirituality, health, and the participant’s experiences in medical school and their personal life.
- The interviews will be conducted in a room at the Department of Preventive & Social Medicine.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

Student health are aware of this study and should the interview create any distress please make use of their counselling staff. The two supervisors are available to speak to any participant who feels distressed by what has been discussed in the interview. The Student Affairs Office from the medical schools at all sites (Dunedin, Christchurch and Wellington) are also aware of this study. The medical schools will not have access to the data gathered.

What Data or Information will be Collected and What Use will be Made of it?

What raw data or information will be collected?

- Your name, date of birth, citizenship, ethnicity, religion, and entry pathway will be collected. The audio of the interviews will be recorded and transcribed.

Who will have access to the data or information?

- The primary investigator (student researcher), supervisors, and transcribers will have access to your data.

How will data or information be securely managed, stored and analysed?
• The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information (name, contact details, audio, after they have been transcribed, anything that could identify the individual etc) held on the participants may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

What data or information will be reflected in the completed research?
• The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

Will participants be provided with the results of the study?
• Results of the study and a copy of their transcript will be offered to the participants.

This project involves an open-questioning technique. The general line of questioning includes spirituality, health, and experiences in medical school and in personal life. The precise nature of the questions which will be asked have not been determined in advance but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project without any disadvantage to yourself of any kind.

Can Participants Change their Mind and Withdraw from the Project?

You may withdraw from participation in the project up to two weeks after the interview without any disadvantage to yourself of any kind.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:

Name of Student Researcher:
Mary Cane Demecillo

Department of Preventive and Social Medicine

Email Address: demma386@student.otago.ac.nz
Name of Supervisors:

Dr Richard Egan

Department of Preventive and Social Medicine

Email Address: richard.egan@otago.ac.nz

University Telephone Number: 03 479 7206 / 027 681 9370

Dr Hamish Wilson

Department of General Practice and Rural Health

Email Address: hamish.wilson@otago.ac.nz

University Telephone Number: 03 479 3726 / 021 2676994

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
## Appendix F – Response Form

**Interested:**

<table>
<thead>
<tr>
<th>Your details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your response: Interested</td>
</tr>
</tbody>
</table>

Thank you for your interest in participating in this study.

By completing this online form, you are affirming that you have read and understood the Information Sheet and therefore consent to participate in this project. You are also affirming that all your questions have been answered to your satisfaction and that you understand that you are free to request further information at any stage.

Please fill out your details below; all information will remain absolutely confidential within the research project. Ten students from those who express interest from each 2nd-year and 6th-year cohorts will be selected to participate in the interviews. As we want to engage with a range of participants, this selection will be based on the details you include in this form. You will be notified via email whether or not you have been selected to be interviewed.

**First Name**

__________________________

**Last Name**

__________________________

**Student ID**

__________________________

**Date of Birth**

__________________________

**Are you**

- Female
- Male
- Other
- Prefer not to say

**Are you a**

- Domestic student
- International student

**Which country were you born in?**

- New Zealand
- Australia
- England
- China (People's Republic of)
- India
- South Africa
- Samoa
- Cook Islands
- Other

**Other**

__________________________

**When did you first arrive to live in New Zealand?**

State month (if known) and year.
Which ethnic group(s) do you belong to

- New Zealand European
- Māori
- Samoan
- Cook Island Maori
- Tongan
- Niuean
- Chinese
- Indian
- Other such as DUTCH, JAPANESE, TOKELAUN. Please state below

Religion/Spirituality - What describes you best?

- Religious
- Spiritual but not religious
- Neither

Give as much detail as you need to name your religion.

eg PRESbyterian, RĀTANA, SUNNI, SIKHISM

How often do you attend a church, synagogue or temple?

- Weekly
- Monthly
- A couple of times a year
- Occasionally ie. funerals, weddings
- Never
- Other

Entry Pathway into the MBChB course

- HSFY
- HSFY (Māori)
- HSFY (NZRIPO)
- HSFY (Rural)
- HSFY (International)
- Graduate
- Graduate (Māori)
- Graduate (NZRIPO)
- Graduate (Rural)
- Graduate (International)
- Alternative
- Alternative (Māori)
- Alternative (NZRIPO)
- Alternative (Rural)

The information you provide in this form will be securely stored in such a way that only the primary investigator (student researcher) and supervisors will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information (name, contact details, audio tapes, after they have been transcribed, anything that could identify the individual etc.) held on the participants may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

Thank you for registering your interest. We will get back to you whether or not you have been selected to be interviewed via email.
Your details

Your response: Not Interested

We thank you for considering our request.

Even though you have decided not to take part, it would be appreciated if you could provide us with your details below; all information will remain absolutely confidential within the research project.

Please let us know why you are not interested in a brief sentence or two (ie. busy, not an interesting topic etc):

First Name

Last Name

Student ID

Date of Birth

Are you

- Female
- Male
- Other
- Prefer not to say

Are you a

- Domestic student
- International student

Which country were you born in?

- New Zealand
- Australia
- England
- China (People's Republic of)
- India
- South Africa
- Samoa
- Cook Islands
- Other

Other

When did you first arrive to live in New Zealand?
State month (if known) and year.
Which ethnic group(s) do you belong to
- New Zealand European
- Māori
- Samoan
- Cook Island Māori
- Tongan
- Niuean
- Chinese
- Indian
- Other such as DUTCH, JAPANESE, TOKELAUAN. Please state below

Religion/Spirituality - What describes you best?
- Religious
- Spiritual but not religious
- Neither

Give as much detail as you need to name your religion.
eg PRESBYTERIAN, RĀTANA, SUNNI, SIKHISM

How often do you attend a church, synagogue or temple?
- Weekly
- Monthly
- A couple of times a year
- Occasionally ie. funerals, weddings
- Never
- Other

Entry Pathway into the MBChB course
- HSFY
- HSFY (Māori)
- HSFY (NZRIFO)
- HSFY (Rural)
- HSFY (International)
- Graduate
- Graduate (Māori)
- Graduate (NZRIFO)
- Graduate (Rural)
- Graduate (International)
- Alternative
- Alternative (Māori)
- Alternative (NZRIFO)
- Alternative (Rural)

The information you provide in this form will be securely stored in such a way that only the primary investigator (student researcher) and supervisors will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information (name, contact details, anything that could identify the individual etc) held on the participants may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.
# Appendix G – Interview Schedule

**Interview Schedule**

| Intro | - Before we begin, I’m just going to go through a couple of specifics  
|       | - Aim of research: what you understand/where that understanding comes from  
|       | - I have allocated 1 hour for this interview, but it really depends on how much you have to say about the topic, so it could take less time.  
|       | - What you should expect.  
|       | - I know when we talked before, that you agreed to be interviewed. I just want to check if it’s still ok with you?  
|       | - I’ll be recording this interview and it will be used for my research. Is that still ok?  
|       | - It’s important for you to know that we Can stop at any point, you can pass any questions and say ‘I’m sorry but I don’t really want to talk about that’, take a break  
|       | - Lastly, I acknowledge... sensitive/distressing/personal stuff. Student health and student affairs. Supervisors.  
|       | - Any questions? |

**Body**

- Background: ethnicity, entry pathway  
- People have different understandings about spirituality – when you hear the word spirituality, what do you think about?  
  - Have you always thought that way. Journey  
  - For some people, cultural background/family has an effect on views  
- Different aspects of health – how do you keep yourself well  
  - Does spirituality play a role into that?  
- Unwell – cope/get back to being well  
  - Does spirituality play a role into that?  
- How might sp/ref impact on patients’ health and wellbeing?  
- Do you think these issues are an important aspect of health care to learn about? Why/why not?  
- Have you received any teaching about spirituality in medical school so far? Did it change/add to your views?  
- If you were to receive teaching about sp, what would you like to know and be able to do?  
- What form of course delivery would you find most effective?  
  - Tutorial, lecture, mentoring, compulsory, optional  
- Has any experience in medical school, so far, prompted you to ask questions related to spirituality  
  - Rest home visit – end of life, after life  
- Would you feel comfortable talking about sp to patients? Do you think it is appropriate to be part of your role as a doctor?

**6th years only:**

- What values, beliefs and theories of your own, separate to medical teaching, guide your interactions with patients so far – where does that come from?  
- In medical school so far, have you been taught how to incorporate your understandings of spirituality into health care assessment and delivery?

**End**

- Thank you – privilege, stranger, one-on-one, personal beliefs  
  - NW voucher  
- Student affairs. Student health  
- Copy of your transcript? Copy of results  
- Any questions?
15 Appendix H – Not interested

Table 15.1 Reasons for not participating

<table>
<thead>
<tr>
<th>Reason</th>
<th>Religious</th>
<th>Spiritual but not religious</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Busy</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Not self-aware / not much to contribute</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not interested</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1 hour is too long for an interview</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear of distress</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discomfort</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not a student anymore</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>No reason provided</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
## Appendix I – Participant Demographics

*Table 16.1 Participant demographics*

<table>
<thead>
<tr>
<th>Demographics</th>
<th>First-Year N = 9</th>
<th>Final-Year N = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>30&lt;</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Māori</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Malay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>British European</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Spiritual/Religious/Neither</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual but not religious</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Religious</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Neither</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Entry Pathway</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSFY</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Graduate</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Alternative</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
17 Appendix J – Definition and effect on health

This table illustrates how someone’s personal definition of spirituality could indicate their understanding of the relationship between spirituality and their own health.

Column one reports how medical students identify themselves, as recorded in the recruitment form or as expressed in the interviews. Column two is how medical students define spirituality. Column three are responses to the question “Does spirituality play a role in keeping yourself well”. Column four are responses to the question “Does spirituality play a role in coping or healing when you are unwell?”. The fifth column is an analysis of their responses.

Table 17.1Relationship between personal definition and perceived effect on health

<table>
<thead>
<tr>
<th>Position</th>
<th>Personal definition of spirituality</th>
<th>Spirituality in keeping well</th>
<th>Spirituality in coping/healing when unwell</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual, Buddhist principles</td>
<td>An understanding of relationship networks. Spirituality encompasses her wonder about forces that might control things.</td>
<td>Provides a sense of connection</td>
<td>Seek help from religious figures. Reframe a situation i.e. Not under my control but under someone else's hands.</td>
<td>Having a sense of connection as a way of keeping herself well reflects her definition of spirituality, which encompasses relationships. Seeking help from religious figures to help her understand the nature of tough situations links back to her definition of spirituality that encompasses a “wondering about forces that might control things”</td>
</tr>
<tr>
<td>Atheist</td>
<td>Larger meaning to life than the physical</td>
<td>No role.</td>
<td>No role. &quot;I'm not somebody to dwell on why me stuff&quot; (when talking about her own chronic condition).</td>
<td>When she says she does not “dwell on why me stuff”, it links back to how she understands spirituality as to do with meaning</td>
</tr>
<tr>
<td>Spiritual, exploring Christianity</td>
<td>Having something to keep you: going, have purpose and hope, help you think that “everything is going to be ok”, moving forward</td>
<td>Reflection and church keep her moving forward</td>
<td>When she finds medical school hard, she thinks about the end when she is able to help people - this keeps her moving forward</td>
<td>the way she keeps herself well and the way she copes with difficult times links back to her view of spirituality as something that keeps her moving forward</td>
</tr>
</tbody>
</table>

Table 17.1 Relationship between personal definition and perceived effect on health
<table>
<thead>
<tr>
<th>Position</th>
<th>Personal definition of spirituality</th>
<th>Spirituality in keeping well</th>
<th>Spirituality in coping/healing when unwell</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual, Catholic upbringing</td>
<td>Having something you enjoy, having something to get you through the good and bad</td>
<td>Doing things he enjoys when he wants a break from things like Med School</td>
<td>Do the things he enjoys to take him away from a bad feeling. Nature, reading a book.</td>
<td>the way he keeps himself well and the way he copes with being unwell goes back to his view of spirituality as having something he enjoys.</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Being self-aware, looking at the bigger picture</td>
<td>Taking a step back from medicine and not get bogged down by it. Reminding self that it isn't her whole world. &quot;I do like the spiritual one. Like, I don’t know, I mean like I try, try and be aware of the bigger picture and look after myself and do things for myself and take time for myself. If that makes me spiritual, then yes.&quot;</td>
<td>Being aware of where you’re at in terms of health when you're sick.</td>
<td>The way she keeps herself well and the way she copes/heals with being unwell goes back to her view of spirituality as being related to self-awareness and looking at the bigger picture.</td>
</tr>
<tr>
<td>Religious</td>
<td>Believing in a higher power when he is unwell</td>
<td>-</td>
<td>Prays to god when has a bad day. Prays to make him feel less stressed.</td>
<td>The way he copes when he is unwell links back to his belief in a higher power.</td>
</tr>
<tr>
<td>Spiritual, Agnostic atheist</td>
<td>Profound feeling, awe for beautiful things, beyond normal sphere of consciousness</td>
<td>&quot;trying to see, see the positives in things. See the beauty in things as well as having the rational mind-set about it.&quot;</td>
<td>-</td>
<td>Part of how he keeps himself well links back to his view of spirituality that encompasses appreciation of the beauty around him.</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Acknowledging there is something bigger, something important about our connectedness. Understanding the world and our place in it.</td>
<td>`for me the spiritual connectedness allows all of those parts to be one rather than separated into different parts.&quot;</td>
<td>“if my perspective on spirituality is this acknowledgement of things greater than yourself and the need for connection, then acknowledging that, that’s kind of lacking in that time is the acknowledgement that spirituality, we’re gonna have to do some recovering”</td>
<td>The way she keeps herself well and how she copes/heals when unwell heavily relates to her understanding that spirituality is to do with connectedness.</td>
</tr>
<tr>
<td>Atheist / not spiritual</td>
<td>She defines spirituality as things not grounded in reality, which she bases off the root word “spirit”</td>
<td>I think there would be some definitions that I would sit with but it just depends on what you think the word means I guess.</td>
<td>-</td>
<td>In her own definition of spirituality, she does not think spirituality has a role in keeping herself well. However, she recognizes that there are other definitions that she would probably resonate with.</td>
</tr>
<tr>
<td>Muslim</td>
<td>Something to hold on to. Belief system.</td>
<td>Extra push. Motivation. Hope</td>
<td>“I’d say I have this belief that it will get better.”</td>
<td>The way she keeps herself well and how she copes/heals when unwell is related to her view of spirituality having to do with.</td>
</tr>
<tr>
<td>Position</td>
<td>Personal definition of spirituality</td>
<td>Spirituality in keeping well</td>
<td>Spirituality in coping/healing when unwell</td>
<td>Analysis</td>
</tr>
<tr>
<td>------------------------</td>
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<tr>
<td>Atheist and spiritual</td>
<td>Appreciation for things that goes beyond the parameters of science ie. Consciousness</td>
<td>Makes him happy and content</td>
<td>Simply being conscious and appreciating that helps him trivialize the stresses that he is going through</td>
<td>The way he keeps himself well and the way he copes/heals when he is unwell clearly links back to his view that spirituality is to do with appreciating that he is a conscious being</td>
</tr>
<tr>
<td>Spiritual, “skeptical humanist”</td>
<td>Willingness to believe, search for meaning</td>
<td>Search for meaning continually and talking about it with people</td>
<td>Search for meaning about when something is going on, asking himself what is important to him now etc</td>
<td>the way he keeps himself well and the way he copes/heals is related to his view of spirituality as encompassing a search for meaning</td>
</tr>
</tbody>
</table>