

Original Publication

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Teaching Third-Year Medical Students to Address Patients' Spiritual Needs in the Surgery/Anesthesiology Clerkship

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Abstract

Introduction: Despite many patients wanting physicians to inquire about their religious/spiritual beliefs, most physicians do not make such inquiries. Among physicians who do, surgeons are less likely than family and general practitioners and psychiatrists to do so. **Methods:** To address this gap, we developed a 60-minute curriculum that follows the Kolb cycle of experiential learning for third-year medical students on their surgery/anesthesiology clerkship. The session includes definitions of religion/spirituality, an overview of the literature on spirituality in surgery, a review of the FICA Spiritual History Tool, discussion of the role of the chaplain and the process of initiating a chaplain consult, and three cases regarding the spiritual needs of surgical patients. **Results:** In total, 165 students participated in 10 sessions over 13 months. Of these, 120 students (73%) provided short-term feedback. Overall, 82% rated the session above average or excellent, and 72% stated the session was very relevant to patient care. To improve the session, students recommended assigning key readings, discussing more cases, role-playing various scenarios, inviting patients to speak, practicing mock interviews, and allowing for more self-reflection and discussion. Long-term feedback was provided by 105 students (64%) and indicated that the spirituality session impacted their attitudes about the role of religion/spirituality in medicine and their behaviors with patients. **Discussion:** We have designed a successful session on spirituality for third-year students on their surgery/anesthesiology clerkship. Students reported it to be a positive addition to the curriculum. The session can be modified for other surgical subspecialties and specialties outside of surgery.

Keywords

Spirituality, Surgical Clerkship, Religion, Patient-Centered Care, Chaplains

Appendices

- A. Spirituality Session Facilitator Guide.docx
- B. Student Self-Reflective Worksheet.docx
- C. Spirituality Session Teaching Slides.pptx
- D. Review of Relevant Literature for Facilitators.docx
- E. A Surgeon's Reflection on Teaching Spirituality.docx
- F. Optional Facilitator Guide for Role-Playing.docx
- G. Spirituality Session Model Evaluation Forms.pdf

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this activity, learners will be able to:

1. Discuss the role of religion/spirituality as part of culturally sensitive, patient-centered care.
2. Integrate spirituality and religion into the perioperative management of patients.
3. Elicit a spiritual history using the FICA Spiritual History Tool as a model.
4. Describe the role of chaplains and how to effectively communicate with them to improve patient care.

Introduction

Background

Since the mid-1990s, there has been a dramatic increase of interest in the role of religion/spirituality (R/S) in health care. The number of articles published in peer-reviewed journals on this topic has increased at a substantial rate.¹ Religion is understood to be an aspect of cultural competence in health care² and a social determinant of health.³ Research findings indicate that the inclusion of R/S in health care improves patient satisfaction⁴⁻⁶ and end-of-life decision making,⁷⁻¹¹ among other important health care outcomes.

Many patients would like their physicians to inquire about their R/S beliefs,¹²⁻¹⁷ yet most physicians do not.¹⁸ One study found that 41% of inpatients wanted a discussion about their R/S concerns, yet only half

had had a conversation about R/S issues.⁵ Many physicians desire to have R/S conversations with their patients but do not because they believe they are inadequately trained, lack adequate time, and/or feel personally uncomfortable.¹⁹ Medical educators have become increasingly aware of these discrepancies and have sought to address them by including coursework on R/S and health in undergraduate medical education (UME) and graduate medical education (GME).

Under the leadership of Dr. Christina Puchalski in 1992, the George Washington University School of Medicine was the first institution to offer an elective on R/S and health.²⁰ In 1999, the Association of American Medical Colleges (AAMC) published the Medical School Objectives Project's (MSOP's) *Report III*, which laid out the first set of outcome goals and learning objectives for medical schools on R/S and health.²¹ In 2011, Dr. Puchalski advanced these efforts again by leading a group, which came to be known as the National Initiative to Develop Competencies in Spirituality for Medical Education, in the creation of spirituality competency domains for medical education, modeled after the Accreditation Council for Graduate Medical Education's competencies.²⁰

Recent reports estimate that between 75% and 90% of U.S. medical schools^{20,22} and over one-half of colleges of osteopathic medicine²³ now include R/S and health in their curricula. In 2010, Koenig, Hooten, Lindsay-Calkins, and Meador reported that 90% of U.S. medical schools have course content or courses on R/S and health, with 73% including the content in required courses and 7% mandating participation in required courses on R/S and health.²² Course content included the role of spirituality in health beliefs and practices, physician prayer with patients, appropriate professional boundaries, spiritual history taking, and the role of health care chaplains.²² In 2012, Lucchetti, Lucchetti, and Puchalski reviewed 38 studies on spirituality in medical education.²⁴ The content of the courses they identified in their review paralleled what Koenig and colleagues had found.

Currently, 13 resources regarding spirituality or religion have been published in *MedEdPORTAL*, and of these, three are out of print. Of the 10 active publications, five deal with end-of-life care,²⁵⁻²⁹ one focuses on geriatric care,³⁰ one is a 1-hour lecture,³¹ and one presents standardized patient cases.³² The remaining two resources, from the Tanenbaum Center for Interreligious Understanding, present a wide variety of cases and clinical scenarios wherein spirituality may be central to the care of the patient.^{33,34} (These Tanenbaum resources may be particularly helpful to facilitators preparing to incorporate the current session into their clerkships.) However, there are no current *MedEdPORTAL* publications that focus on the role of spirituality in surgery and none that integrate chaplains into the educational method or fully describe the role of the chaplain in their content.

Despite these advances in medical education and a clear desire on the part of patients for physicians to inquire about their R/S needs,¹²⁻¹⁷ physicians consistently fail to do so.¹⁸ The most frequently cited reasons for this are not enough time during the visit, inadequate training, and discomfort in general with these types of spiritual discussions.^{19,35-37} Among physicians who do have R/S discussions with their patients, surgeons are less likely than family practitioners, general practitioners, and psychiatrists to delve into the R/S concerns of their patients.¹⁸ However, most surgical patients want their surgeons to take a spiritual history. Taylor and colleagues³⁸ surveyed 147 general surgery patients and 214 orthopedic patients about their frequency of prayer. Patients from both clinics reported a significantly higher percentage of daily prayer—71% orthopedic and 72% general surgical—compared to the national average of 60% for adults. The majority of respondents from each clinic—81% orthopedic and 85% general surgical—agreed that surgeons should be aware of their patients' religious beliefs and spiritual practices. Patients overwhelmingly expected their surgeons to take a spiritual history—56% orthopedic and 74% general surgery—as well as wanting their surgeons to refer them to chaplains—57% orthopedic and 74% general surgery—for spiritual issues. Most importantly, 57% of orthopedic and 74% of general surgical patients agreed that inquiry by a surgeon into their religious beliefs and spiritual practices would increase their trust in their surgeon.

Spirituality Training at the Icahn School of Medicine at Mount Sinai

The Icahn School of Medicine at Mount Sinai initiative that we present here began in 2014 as an interdisciplinary partnership. The initial group comprised three individuals: one faculty member (MD) from the Department of Medical Education, one faculty member (MD) from the Human Rights Program, and one faculty member (PhD) from the Office of Diversity and Inclusion. All three of us shared the belief that the UME core curriculum should include comprehensive, longitudinal training on patients' R/S needs. At this time, M1 and M2 students were already participating in a mandatory 2-hour session on how to take a spiritual history that was included in the Icahn School of Medicine's Art and Science of Medicine (ASM) course. ASM is a 2-year, preclinical course that provides the knowledge, clinical skills, and professional attitudes essential for clinical practice, as well as early, meaningful, and sustained patient contact in ambulatory and inpatient settings. We began our initiative by assessing perceptions among the third-year clerkship directors regarding needs and gaps in the curriculum on spirituality and medicine. We developed and administered a 27-question survey aimed at our clerkship directors, inquiring about the need to further teach students how to ask about patients' spiritual needs, integrate the findings into patient management, and make a referral to a chaplain, when appropriate. The results of the survey revealed a strong interest on the part of the surgery and psychiatry clerkship directors in working with our team to develop a spirituality training session for their students. Our first initiative focused on the surgery/anesthesiology clerkship (which is a combined clerkship at the Icahn School of Medicine).

During the period we were analyzing the outcome of our needs assessment survey, the Tanenbaum Center for Interreligious Understanding invited our three-member team along with the director of spiritual care and education at Mount Sinai to review a curriculum for medical schools that Tanenbaum had developed for another medical institution.³³ Tanenbaum's curriculum provided case studies for students to engage with that focused on patient decision making as being impacted by the patient's religious and spiritual beliefs. Together, our team entered an envisioning phase of the project, deepening our understanding of what the students' learning needs were and where we might best address those needs in the curriculum. We made an important decision at this point: Ideally, we would work to develop an integrated longitudinal comprehensive spirituality and medicine curriculum across the school's 4-year program. Given that the M1 and M2 curriculum already incorporated some spirituality history-taking training, we focused first on developing a curriculum for third-year students, with the intent to develop an elective for fourth-year students subsequently. Also, at this time, our Spiritual Care Department had been awarded center status, becoming the Center for Spirituality and Health at the Icahn School of Medicine at Mount Sinai. The director of education for the center (a senior chaplain and Association for Clinical Pastoral Education–certified educator) then formally joined our team.

A note on how the new Center for Spirituality and Health at the Icahn School of Medicine functions: The center provides chaplaincy services to patients and their loved ones, engages with local communities of faith to promote health screenings, conducts research on the intersection of spirituality and health, and provides education to clinical pastoral education (CPE) interns and residents and to medical students. The Department of Spiritual Care and Education at Mount Sinai Hospital is part of that larger center and focuses its efforts on meeting the religious, spiritual, and emotional needs of patients and their families through the provision of chaplaincy care. The department comprises a director, six staff chaplains, a chaplain fellow, four CPE residents, three to six CPE interns, a certified CPE educator, and a CPE educator-in-training. Chaplains receive requests for consults based on informal and formal spiritual screens conducted throughout the hospital and in the outpatient oncology setting. Informal screening occurs when a health care professional notices spiritual or emotional distress through routine interactions with patients. Formal screening questions are asked in the inpatient nursing assessment and in all of the outpatient oncology settings. When spiritual distress is observed, whether formally or informally, a consult is placed through the electronic medical record, a phone call to the Department of Spiritual Care, or in person. Chaplains are assigned to services and floors, not to specific religions. For example, there are chaplains and CPE residents/interns assigned to the oncology, cardiology, pediatric, HIV/AIDS, and critical care services. Professional chaplains are trained to provide spiritual and emotional support to persons of any

religious and/or spiritual worldview. Additionally, professional chaplains specialize in a religious or spiritual tradition to which they belong and from which they have received training. When patients express particular R/S needs, then chaplains from a concordant tradition may meet those needs. If a request for a specific R/S need arises that is outside a chaplain's area of expertise, then the chaplain serves as a bridge between the hospital and local community clergy to facilitate meeting the need.

The director of education for the Center for Spirituality and Health and the surgery/anesthesiology clerkship director now coteach the spirituality session presented here. We focused our efforts on integrating the spirituality and medicine training, along with some of Tanenbaum's framework and cases, into the surgery/anesthesiology clerkship because, as documented in the literature, surgeons are less likely to have R/S discussions with their patients and we had identified a strong partner in our own surgical department through our needs assessment.

Methods

Description of Intervention

We developed a 60-minute session entitled Addressing Patients' Spiritual Needs in the Surgery/Anesthesiology Clerkship (hereafter, the spirituality session) to help students improve their ability to contribute to spiritually effective care of patients they encounter in the surgery/anesthesiology clerkship. We established our learning objectives consistent with those developed and adopted by the AAMC as part of the MSOP's *Report III*²¹ and the National Initiative to Develop Competencies in Spirituality for Medical Education.²⁰ Educational methods included cofacilitation by a surgeon and a chaplain, guided reflections to explore the impact of spirituality on the students' clinical experiences, brief didactic overviews of key concepts, and case-based discussions. We targeted third-year medical students on a surgery clerkship as our primary audience; however, the session can easily be modified to include more senior students and surgical residents and can also be modified for other specialties.

We designed the session to follow the Kolb cycle of experiential learning.³⁹ The Kolb cycle includes a concrete experience, reflective observation, abstract conceptualization, and active experimentation. All students entered the session with lived experiences concerning spirituality and religion in their personal lives and within medical education. In preparation for the session, the team gathered beforehand, reviewed the proposed time line for presentation of the material, and decided on key roles for each facilitator (see the facilitator guide, Appendix A).

We began the session with a series of self-reflection questions (Appendix B) designed to ground the students' learning in their concrete lived experiences. These self-reflection questions were a modification of the FICA (faith and belief, importance, community, address in care) tool for spiritual assessment.⁴⁰ After this reflective observation, we asked students to assess their knowledge, attitudes, and skills regarding spirituality and medicine through a series of questions presented on slides with audience response capabilities (Appendix C, Slides 3-8). We facilitated abstract conceptualization by presenting a summary of published data on spirituality in medicine in general and within surgical fields in particular. Select data were depicted within the slide set (Appendix C, Slides 11-14), with a more comprehensive document provided as a resource for facilitators (Appendix D, a review of the relevant literature). These data served as a context within which students could reconceptualize their prior experiences. Students then participated in active experimentation by progressing through a series of cases. The surgeon and chaplain facilitators modeled their respective approaches to each case and reflected openness by sharing similar experiences within their own careers. This cofacilitation demonstrated the interdisciplinary collaboration necessary for spiritually effective care, as well as the unique skill sets contributed by the surgeon and the chaplain as they approached the same case. At the end of the session, students revisited the initial set of knowledge, attitudes, and skills questions and reflected on potential growth in knowledge and skills, as well as on changes in perspective.

Equipment and Personnel

We designed this session to be cofacilitated by a surgeon and a chaplain, with a minimum of four and a maximum of 30 learners. Ideally, the session should occur early in the surgical clerkship block, so students have time to apply the skills that they learn in the session during the remaining weeks of the clerkship. Faculty should have experience in small-group facilitation, including facilitated reflections. The surgeon facilitator does not need any specialized training in spirituality and medicine. However, in our experience of developing and delivering the session, preceptors benefited greatly from periods of self-reflection. A brief discussion of a surgeon's personal journey in teaching this material is provided in Appendix E. We suggest surgeon facilitators read this document as part of their preparation for the session. The optional facilitator's guide for role-playing (Appendix F) is provided to guide facilitators in the delivery of a 90-minute version of the session that includes role-playing.

Ideally, facilitators should deliver this session in a room with chairs that can be rearranged into circles for groups of over 20 learners. Audiovisual requirements include a computer with projector and PowerPoint setup. If the facilitator wishes to use a live audience response system for portions of the didactic sections, an internet connection is also required. Model evaluation forms (Appendix G) for short-term and long-term feedback can be personalized with the facilitators' names and dates of the presentation and printed for use at the end of the session or can be distributed electronically after the session via an online data-capture tool such as REDCap.

Assessment

Our team has taught the spirituality session 10 times during the surgery/anesthesiology clerkship at the Icahn School of Medicine at Mount Sinai over a 13-month period. In developing the assessment of our spirituality session, we sought to achieve two major goals: (1) an assessment of the quality of the session itself as perceived by the students immediately after they experienced it and (2) a longer-term assessment of the impact the session had on their attitudes and behaviors. Thus, our assessment was two phased, comprising administration of short-term and long-term surveys. The Mount Sinai Institutional Review Board determined this project to be exempt human research as defined by U.S. Department of Health and Human Services regulations (45 C.F.R. § 46.101(b)(4)).

Immediately after each session, all participants (15-19 students per session) received an invitation via REDCap to fill out an evaluative survey that invited feedback on the session based on quantitative ratings and qualitative comments (Appendix G). Students were asked to complete four questions: (1) the date of their session, (2) their assessment of the overall quality of the session (from poor to excellent on a 5-point scale), (3) their determination of the relevance of the session to patient care (from not relevant to very relevant on a 3-point scale), and (4) a prompt for comments regarding their overall experience and ways to improve the session. If students did not complete the survey on first invitation, they received two automatic email reminders over the course of 2 weeks.

We also conducted a second assessment 15 months after the commencement of the first spirituality session. All students who had participated in all sessions ($n = 165$) received an invitation via REDCap to fill out a second survey, which focused on assessing whether the session had achieved its objectives and the impact, if any, it had on their clinical interactions with patients. If students did not complete the survey upon receiving the first invitation, they received two automatic email reminders over the course of 2 weeks.

Results

Immediate Postsession Survey

Over the course of 13 months, 165 third-year students participated in the 10 sessions. Of these students, 120 responded to our immediate postsession survey, for a response rate of 72.7%. The findings indicate that our spirituality session was consistently well received by students.

Quantitative data: Figures 1 and 2 show quantitative data from the immediate postsession surveys. These data demonstrate learner satisfaction with the quality and relevance of the session. Overall, almost 82% percent of respondents rated the session above average or excellent (Figure 1). Additionally, almost 72% of participants stated that the session was very relevant to patient care (Figure 2). Review of findings from each individual session showed there was no significant variance in results according to specific sessions.

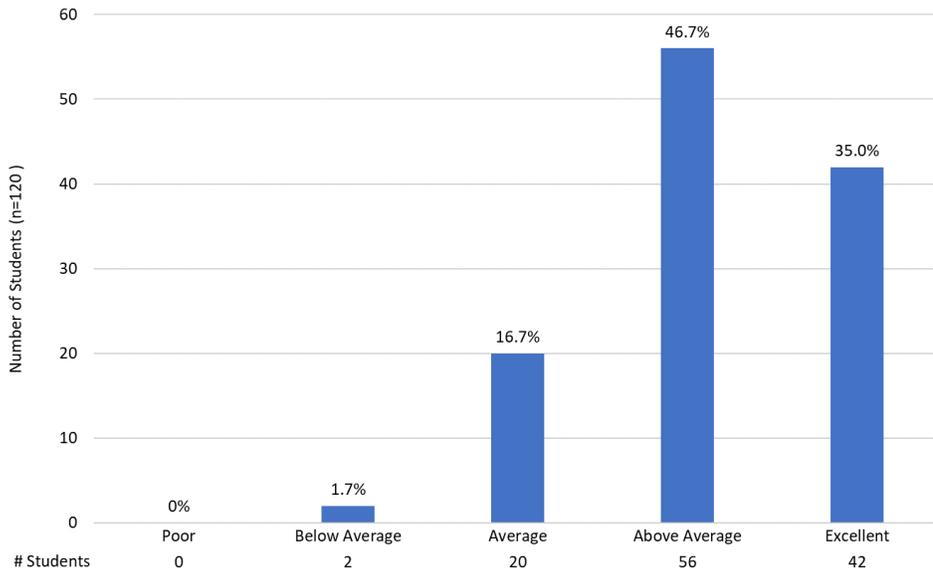


Figure 1. Overall session quality. The bar graph shows the number of students rating the session’s quality on a 5-point scale ranging from poor to excellent.

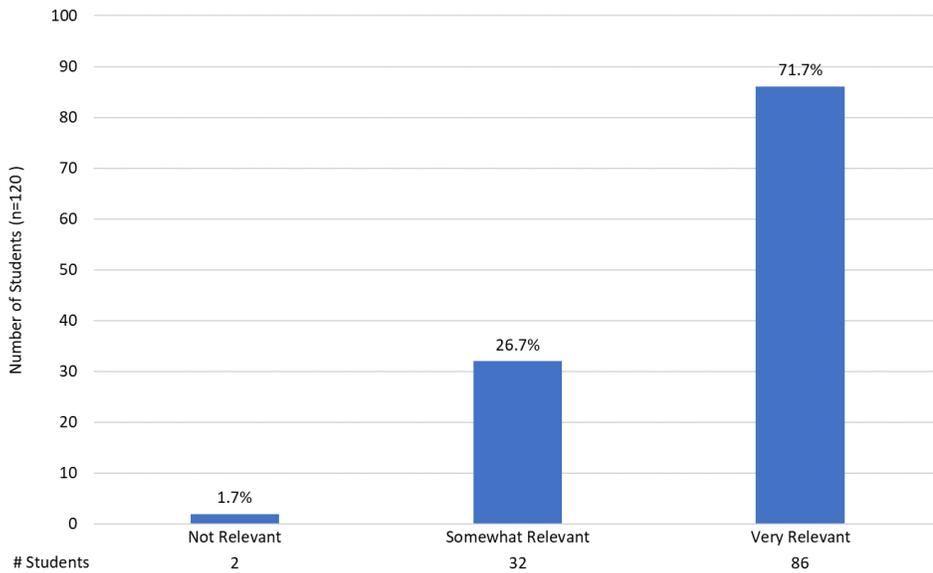


Figure 2. Relevance to patient care. The bar graph shows the number of students rating the session’s relevance to patient care on a 3-point scale ranging from not relevant to very relevant.

Qualitative data: Of the 120 students across all sessions who responded to the survey, 115 submitted comments in response to the following open prompt: “Please comment on the quality of the session—tell us, for example, what you liked, disliked, found particularly useful and/or ideas for improvement.”

Qualitative comments: Almost all of the comments were positive, including the following:

- “This is a beautiful addition to the medical curriculum and a topic that is important to so many patients.”
- “While this session could be in another clerkship/module, I thought it fit nicely in the surgery/anesthesiology portion as a time to slow down, reflect on the patients we have seen and also to be aware of the spirituality of the patients, for which students on surgery can often have the time and awareness to notice. I believe the session should continue and remain including practical info and open-ended discussion.”
- “It was very helpful to learn about the FICA tool for addressing patients’ spirituality needs. I also liked that students shared their own experiences from the OR. In addition, it was helpful to learn how to contact a chaplain on AMION. Overall, this session was interesting and informative.”
- “Fabulous lecture! So glad it’s in our curriculum!!”

Constructive feedback: Recurrent themes that arose in the students’ constructive suggestions included assigning key readings, discussing more cases, role-playing various scenarios, inviting patients to speak, practicing mock interviews, and allowing for more self-reflection and extensive group discussion.

Long-Term Impact Survey

Of the 165 students who participated in the 10 sessions over the course of 13 months, 106 (63.6%) responded to our long-term impact survey. The findings indicate that our spirituality session for the most part met our objectives and had an impact on students’ clinical interactions with patients.

Quantitative data: Overall, of the 106 students who responded, 20% had participated in the spirituality session more than 12 months prior to filling out the survey, 47% had taken the session 6-12 months previously, and the remaining 33% had taken it within the past 6 months. After taking the session, 79.1% of respondents either strongly agreed or agreed that R/S is important in providing culturally sensitive, patient-centered care. Just over 12% of respondents said that since participating in the spirituality session, they had almost always or often integrated R/S into the management of their patients; another 41.9% said they sometimes did (see Figure 3).

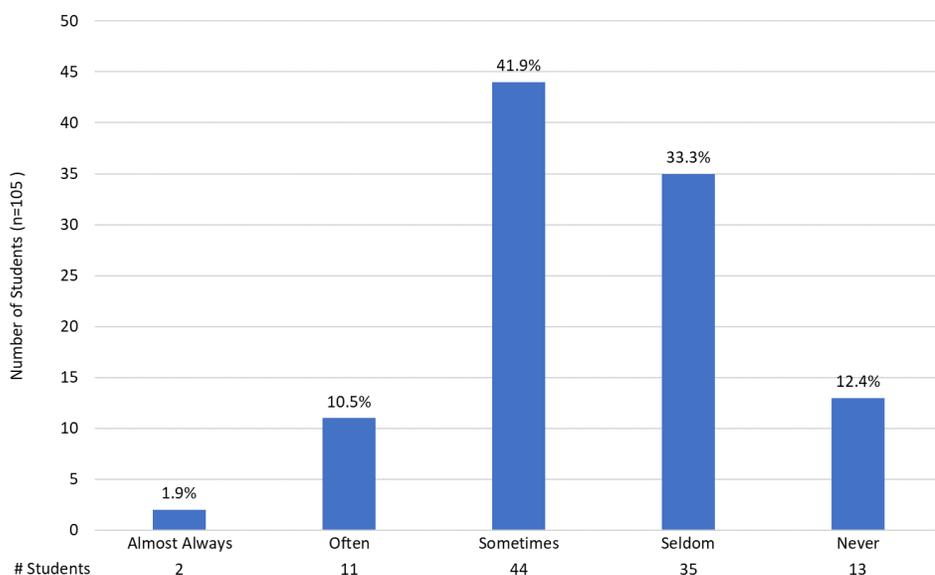


Figure 3. Integration into patient management. The bar graph shows the number of students indicating they have integrated religion/spirituality into their patient care, rated on a 5-point scale ranging from never to almost always.

While respondents indicated they had incorporated R/S into their care, very few ($n = 5$, 4.8%) said that they had specifically used the FICA tool to elicit a spiritual history. A majority of respondents indicated that since participating in the spirituality session, they understood the role of the chaplain as part of the medical team (a great deal, 21.0%; a considerable amount, 51.4%; and a moderate amount, 15.2%). Since participating in the session, 38.1% of respondents said that they had either called a chaplain or suggested to the team that a consult with a chaplain be requested for a patient (see Figure 4).

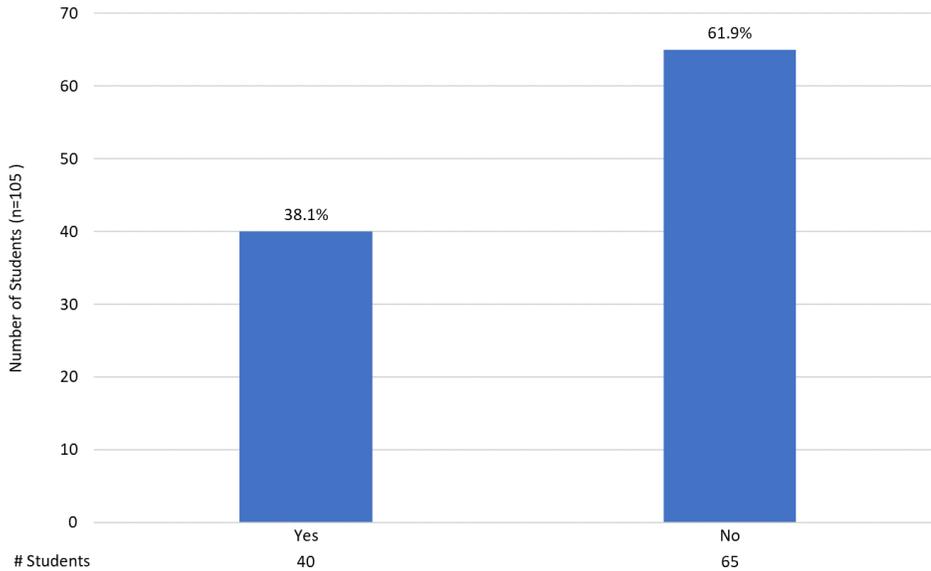


Figure 4. Requested a chaplain consult. The bar graph shows the number of students indicating they themselves have requested or have recommended to others that a chaplain be called for a consult.

Finally, almost half (46.7%) of respondents indicated that the spirituality session had improved their approach to patient care to a great extent or a moderate extent (see Figure 5).

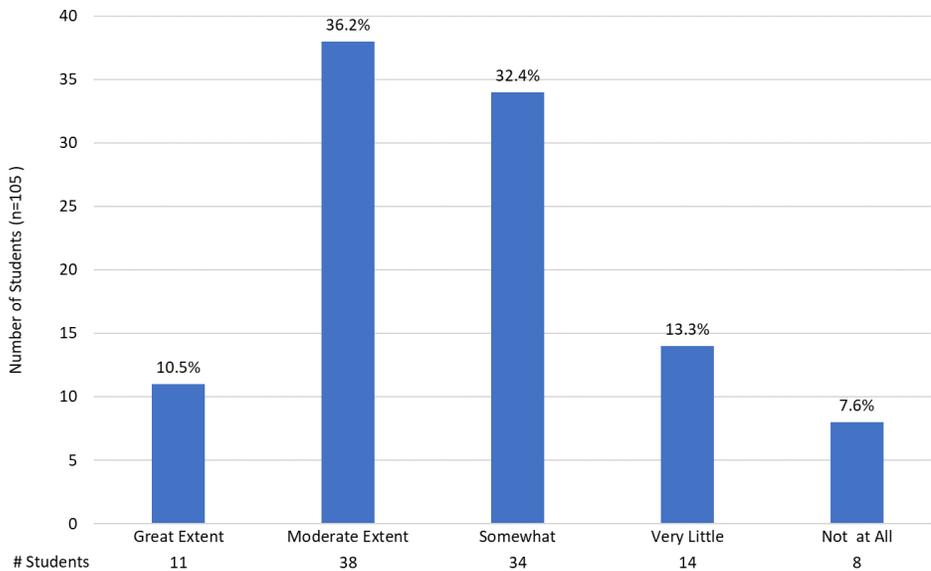


Figure 5. Improved approach to patient care. The bar graph shows the number of students indicating the session improved their approach to patient care, rated from not at all to a great extent.

Qualitative data: Of the 105 students across all sessions who responded to the long-term impact survey, 24 (22.8%) submitted comments in response to the following open prompt: “Any last thoughts, or feedback on the value of the Spirituality in Surgery/Anesthesiology Session?”

Qualitative comments: Most of the 24 comments on the long-term impact survey were positive, although there were a few negative ones:

- “Glad we have a session on including a chaplain in the care team—interesting that this session occurred during surgery!”
- “Waste of my time.”
- “I think this session was valuable and provided a nice perspective on the role that spirituality plays in patient care.”
- “I think the workshop is great and is essential training to clinicians.”
- “An interesting session, but not fully integrated into the surgery curriculum—no one else mentions it beyond this session.”
- “I didn’t end up having many instances where I used the FICA tool, but looking back on the past few months, I think there were definitely instances where I could/should have. If anything, I think filling out this survey has reminded me of that, and I will look for opportunities to implement the FICA tool going forward—I think it is a great, easy-to-use framework. Would definitely keep the session during the clerkship.”

Modifications: We taught the first spirituality session in January 2017 and then made major revisions to the content in May 2017 in response to the immediate postsession survey feedback provided by students and the reflections at our monthly team debriefs. The feedback made us realize the need to better focus the content of the session. We narrowed the focus from the more general theme of spirituality and medicine to exploring specifically the role of the chaplain as part of the surgery/anesthesiology team, including instruction regarding a chaplain’s training and her/his specific roles.

The surgeon facilitator read chaplain notes from some of her own patient charts to demonstrate the chaplain’s various roles as part of the medical team. We focused on the ways in which chaplains are skilled at eliciting psychosocial-spiritual information relevant to the plan of care. We also included a section on stereotypes and misconceptions regarding the role of the chaplain that may be held by patients and providers. Examples included misconceptions such as that chaplains proselytize patients, chaplains provide care only to people of the same religion, and chaplains visit patients only when they have received bad news or when death is imminent. In the course of teaching the session, we found that oftentimes, it was difficult for the students to settle into the session as it was so different from their usual experiences on the surgical rotation. Thus, at the beginning of the session, we added a 2-minute deep-breathing exercise and a moment of silent meditation to set the proper tone. We also introduced a self-reflection worksheet with time to reflect.

Based upon further feedback, we revised the session again in September 2017. At this time, we realized the importance of presenting a more thorough review of the current research. We expanded the review of data we presented on spirituality and surgery taken from five highly relevant papers published in the literature. In addition, because students voiced their discomfort in calling consults themselves, we added a discussion specifically aimed at the institution’s process of initiating a consult with a chaplain, especially outside of a palliative care context, within the context of a hierarchical surgical culture. We provided granular content as to how to consult a chaplain and when it was appropriate to do so. We found it essential to discuss the role of the medical student on the team and the presumed hierarchy specifically on the surgical team. It was important for medical students to realize that calling a chaplain consult was a skill that they could and should acquire. Even within the hierarchy of a surgical team, it was clearly within the scope of a medical student’s role to feel comfortable initiating a consult and to be able to know how to request one.

Discussion

We developed and implemented a session on spirituality and medicine specifically designed for the third-year clinical clerkship in surgery/anesthesiology. We focused on surgery because, as documented in the medical literature, surgeons are among the least likely of practicing clinicians to engage in R/S conversation with their patients.¹⁸ We also, through our needs assessment, had established a critical need in the surgical rotation at our institution and identified a supportive surgeon who was personally interested in spirituality and medicine and willing to be one of our faculty preceptors.

One of the strengths of our approach is the interdisciplinary nature of our team in both the development of the session and the teaching of it. A unique aspect of our spirituality session is the team teaching by a surgeon and a chaplain. In the session itself, the surgeon and chaplain model how they cooperate on the floor and also utilize the chaplain's chart notes as a teaching tool. Another unique aspect is the use of specific, surgically focused vignettes (see Appendices A & C). For example, one case explores the issues presented when a 25-year-old woman who suffered burns refuses a skin graft when she learns the graft is porcine. Another case considers the issues raised by a 48-year-old man who requires an urgent exploratory laparotomy due to acute abdominal pain and wants to wear his religiously meaningful necklace into the surgery, "in case anything happens to me."

Overall, the session was extremely well received by the 165 medical students who participated, with almost 80% of respondents rating the session above average or excellent and almost 70% stating that it was very relevant to patient care. Students offered a number of suggestions on how to enhance the session. They requested even more time for reflection and discussion, more surgical case vignettes, opportunities for role-playing, presentations by real patients, modeling of interviewing skills by residents and/or attendings, and counseling on how to raise the value of spirituality and medicine among the health care team on the wards. Given the feedback, we are considering adding a second session during the surgical/anesthesiology clerkship that would allow for the accommodation of many of these suggestions, with a particular focus on students' experiences in integrating these concepts into their interactions with their surgical patients. Thus, the training would encompass two sessions within the 8-week surgical block.

The data from the long-term impact survey indicate that the spirituality session was successful in achieving our stated objectives for a majority of students. Responses suggested that most students came to appreciate the role of R/S as part of culturally sensitive, patient-centered care. Furthermore, students reported that they were integrating R/S into their management of patients. However, students were not, after participating in the session, specifically utilizing the FICA tool to elicit a spiritual history. It is important to note that the spirituality session did not attempt to train students to use this tool. The session merely introduced the concept and availability of the tool to them. Finally, a majority of students indicated that they understood the role of chaplain, and almost one-half had either called a chaplain or recommended a consultation with one for a patient of theirs after having participated in the spirituality session. This was a change from what students had previously reported: At the beginning of each spirituality session, the surgeon facilitator asked for a show of hands of how many students had ever called a chaplain. In each session, typically only one student would indicate that he or she had called a chaplain, usually on the palliative care rotation.

In teaching this session, the team experienced several notable limitations. Students' clinical experiences with R/S issues were varied depending on when they took the session during the academic year. Some students had exposure to similar content in their palliative care rotation, whereas others did not, and thus, the facilitators were challenged in accommodating various levels of knowledge and skill. A second limitation was the time constraint. Some students expressed a desire for role-plays, which would require additional time and resources that were not available to us. In addition, we did not assess students' skills prior to and/or after the session. This could be achieved with postsession observed simulated patients or real patient encounters; however, each would also require more time and resources. We worked around these limitations by changing the content slightly based on students' prior clinical experience and the time

of year and by making the session interactive. Furthermore, a potential limitation for others using this curriculum is the availability of chaplains to cofacilitate the course and surgeons to coteach it. Finally, there is the challenge of finding the time and place in the curriculum to include this session because of competing demands and priorities.

Moving Forward

The spirituality session that we describe here can be modified for other specialties, including surgical subspecialties and specialties outside of surgery. Surgery may be one of the most difficult services on which to teach and model spirituality, and thus, the session may be easier to replicate in other environments. In the needs assessment of our clerkship directors that we undertook before designing our educational intervention, we also identified interest in our psychiatry department to include such trainings in the psychiatry clerkship. Among our next steps, we seek to develop a working partnership in psychiatry, so as to include spirituality sessions in the psychiatry clerkship, and then move to still other clinical clerkships.

We are also exploring how to deepen the education experience at other points in UME. We have recently received approval for offering a spirituality and medicine elective to third- and fourth-year students. This 2-week course will enable students to reflect on their own spirituality and learn how it can be nurtured as part of their professional growth, increase their skill and comfort in taking a patient's spiritual history, apply the understanding of a patient's spiritual and cultural beliefs and behaviors in appropriate clinical contexts, increase their knowledge of research on spirituality and medicine, and gain an understanding of the role of the clergy and other spiritual leaders, as well as how to collaborate with them. We are also including a spirituality and medicine session in the 2-week orientation-to-internship block that occurs at the end of the fourth year. We anticipate integrating these sessions further into GME training for our interns and residents at Mount Sinai. To achieve success in both the UME and GME arenas, we recognize the need to engage in faculty development as well.

We have learned many other invaluable lessons from our interdisciplinary team collaboration. Our work has stimulated us to ask even broader questions about the potential of this curriculum to train physicians and other health care providers. Can focusing on the spirituality of patients and helping them to better cope with their health challenges somehow have a positive impact on the physicians and other team members who care for them? Can a health system encourage spiritual practices among its staff as a part of a workplace wellness initiative? Can this awareness be used in addressing physician burnout and the resulting impairment, which is often impacted by the moral and ethical compromises providers too frequently are forced to make in their daily practice? These questions have inspired us to continue to work to expand and integrate this curriculum throughout UME and GME as part of our striving to provide culturally sensitive, patient-centered care, as well as foster the well-being of the clinical providers who care for those who are sick and in need.

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Ethical Approval

The Mount Sinai Health System's Institutional Review Board approved this study.

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