'Spirituality in Medicine': A Training Programme for Medical Students in Providing Spiritual Care to Patients and Their Loved Ones. A Case Study from the Collegium Medicum in Bydgoszcz, Nicolaus Copernicus University in Torun, Poland

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1. Introduction

Working with people who experience suffering is a significant challenge for healthcare professionals. Diagnosing patients' needs, preparing treatment plans, and providing care and support require a deeper engagement beyond medical knowledge, techniques, and protocols. The resolution of complex clinical situations may be predicated on the relationship that develops between a professional and a person in need of help. That formed between a healthcare professional and a patient is particularly challenged through the situation of illness, suffering, or death, which requires intimate knowledge regarding the patient's story. In promoting an holistic approach to patient care, where one is focused on whole-person caregiving as opposed to a single organ that is failing, the breadth of knowledge of medicine and medical protocols may prove to be insufficient in this context. The wider context and impact of this life-changing event also needs to be considered. Medicine is a field in which the influence of personal, emotional, and spiritual aspects on the course of illness and/or patients' recovery and emotional balance is becoming increasingly prominent[1]. Enhanced spiritual care demonstrates better coping with disease, patient satisfaction with treatment and care, greater well – being and quality of life (Siddall et al. 2015) as well as reduced anxiety and depression (Hughes et al. 2004; Bekelman et al. 2007). Patient are also more able to cope with their disease and have more positive attitude despite a difficult health situation (Brady et al. 1999). The relationship with quality of life, coping with the disease, and the received spiritual support confirm that spirituality is an essential part of human life and patient care (Vandenhoeck 2013).

Looking at patients holistically sets new standards of treatment, care and support, making it necessary for healthcare professionals to learn interpersonal skills which include the ability to

[1] See, for example, research on the impact of a mental condition or emotions on coping with a difficult situation such as an illness, suffering, or mourning.

care for patients' spiritual needs and understand, where possible, their existential quest. Such an approach enforces changes in medical curricula to ensure that students receive substantive learning in relation to whole person care. This article presents the first such programme as a distinct curriculum for medical students in Poland. It discusses the development of the programme and its successful implementation at the Collegium Medicum in Bydgoszcz of the Nicolaus Copernicus University in Torun.

2. Materials and Methods

The Development and Implementation of the 'Spirituality in Medicine' Programme at the Collegium Medicum in Bydgoszcz of the Nicolaus Copernicus University in Torun supported by the Polish Association for Spiritual Care in Medicine (PASCiM), was launched in 2017. At that time, the following focus areas were identified:

1) Preliminary work on the content of the programme, agreement on key concepts, terms, and definitions;
2) Consultations with coaches and teachers of spirituality in medicine from international centres;
3) Analysis of the available research and publications on teaching spirituality in other parts of the world;
4) Development of the first programme on spirituality for medical students, confirmation of approval from the Faculty of Medicine authorities, and implementation of the programme at the Collegium Medicum in Bydgoszcz;
5) Development of a tool for assessing whether the participation in the program has potential to change the students' knowledge and attitude to spiritual suffering and spiritual care for their patients;
6) Regular monitoring of the programme and its effectiveness.

2.1. Preliminary Work on the Content of the Programme, Agreement on Key Ideas, Concepts, Terms, and Definitions

A curriculum or workshops capable of meeting the needs of professionals must always be founded on a well-defined concept of the topic in question. In order to prepare an innovative programme of medical education in spiritual care, it was necessary to develop a common definition of spirituality that would encompass all the elements recognised by us as crucial and therefore fundamental for the programme. The concept thus defined needed to cover the sphere of human religious experience and practice; however, it also had to represent a broader concept referring to various forms of existential search and other significant values in human life. Adopting such a construct in our training programme and then using it in practice offered medical students an opportunity to examine the deepest layers of what it means to be human, areas which can provide strength but may also cause personal struggle, doubts, pain, and despair. Through this approach it was proposed that it would be easier for them to realise that their patients can suffer not only physically but also spiritually; consequently they are in need of spiritual care and support, which should be an integral part of the treatment process (Saunders 1964, 1993; Pace and Lunsford 2011).

Two definitions of spirituality were used for the development of the assumptions and plan for the programme. The first was the definition proposed by the European Association for Palliative Care (EAPC) Task Force in 2011 (revised in 2020), who consider 'spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred' (revised definition from 2011) (Best et al. 2020, p. 2). The second definition, perhaps more closely aligned with

our project, was developed by PASCiM, which defines spirituality as a dimension of human life that relates to transcendence and other existentially important values (Krajnik 2017; PASCiM 2021). Based on the EAPC approach to spirituality, PASCiM similarly recognizes different dimensions of spiritual experience which include:

1) Religiousness of a person, especially his/her relationship with God, personal beliefs, and religious practices, as well as community interaction;
2) Existential quest, especially with regard to the meaning of life, suffering, and death, issues of own dignity, who one actually is as a person, a sense of individual freedom and responsibility, hope and despair, reconciliation and forgiveness, love and joy;
3) Values by which a person lives, especially with regard to oneself and others, work, nature, art and culture, ethical and moral choices, and life at large (Krajnik 2017; Best et al. 2020; PASCiM 2021).

These definitions and its dimensions provided the basis for planning a programme that would be consistent with the aims and learning outcomes that we wanted to achieve.

2.2. Consultations with Coaches and Teachers of Spirituality in Medicine from International Centres

Another factor that made a significant contribution to the programme's final shape was extensive consultations with practitioners and authors of spirituality classes/programmes in other European countries and around the world. One was Professor Richard Groves, founder of the Sacred Art of Living Centre programme (SALC 2021), himself a dedicated teacher with many years of experience in lecturing on spirituality in the United States and across the globe. As a result of these consultations, the authors of the newly developed Polish programme were able to participate in a training course for future teachers of spiritual growth held by Professor Groves in Ireland and Poland, during which they had the opportunity to familiarise themselves

with his spirituality workshops, programme, core topics, and methodology, specifically their Spiritual Health Assessment tool to assess patient' spiritual pain (Groves and Klauser 2009; SALC 2021). Another person that was approached was Professor Christina Puchalski, international scholar in the field of spirituality and a keynote speaker at a 2017 conference entitled Winter Summit in Palliative Medicine: 'Heart and Spirit in Palliative Care' (2017). Her speech, as well as other lectures about the work of healthcare professionals and its practical aspects, also in the area of spirituality, provided yet more proof regarding the importance of the newly developed programme. Furthermore, Professor Philip Larkin, a palliative care expert in the area of compassion and selfcare as also advised on important components of the course; these aspects are vital in improving the skills of healthcare professionals and, consequently, the quality of care. As a result of these consultations and discussions, the authors of the programme were able to learn more about the tools currently used in Europe and internationally for studying and diagnosing the spiritual needs of patients, as well as planning a comprehensive treatment and support for them.

2.3. Analysis of the Available Research and Publications on Teaching Spirituality in other Parts of the World

A review of existing international programmes was conducted (Puchalski and Larson 1998; Bennett et al. 2014; Paal et al. 2014; Harbinson and Bell 2015; Wenham et al. 2021). This included an in-depth analysis of the course curricula and teaching methods to underpin the proposed programme. Consequently, ideas were chosen that were not only in line with the adopted definitions but also in compliance with the highest available global standards of spirituality teaching [article in preparation].

2.4. Development and implementation of the first distinct Programme on Spirituality for Medical Students

The proposed programme as an obligatory course for medical students was approved by the authorities of the Faculty of Medicine of the Collegium Medicum in Bydgoszcz, Nicolaus Copernicus University in Torun, and introduced for the first time during the 2018/2019 academic year. It envisaged work with students throughout the subsequent years of studies (i.e. from 2nd to 5th year, a total of 48 teaching hours) (Table 1). Although the programme has undergone certain modifications since its inception, the status of the classes (compulsory) remains unchanged. In the years 2019/2020 and 2020/2021, the entire programme was implemented over a course of 22 teaching hours for the second-year students. However, from the academic year 2021/2022 it is to be taught during the 2nd and 5th years of medical studies (the latter as a part of palliative medicine module) reflecting a change in the general strategy of University, rather than student feedback. However, as a result, these developments have created the unique opportunity to monitor and compare the efficacy of different approaches to the teaching spirituality to medical students based on the important question if it is better to teach spirituality every year or just at the beginning and at the end of medical studies.

2.5. Development of a Tool for Assessing whether the Participation in the Program Change the Students' Knowledge and Attitude to Spiritual Suffering and Spiritual Care for their Patients

Based on the benefits of spiritual care highlighted earlier, it was crucial for the spirituality programme to offer tools capable of assessing not only the knowledge of spirituality as acquired by medical students, but also the impact of teaching spirituality on the improvement of their skills and sensitivity in this area, therefore enhancing the students' competences and

effectiveness as future doctors. Students are asked to fill in this questionnaire before and after their participation in the programme on spirituality. This structured and standardised psychometric tool prepared to evaluate the course is a subject of another publication (in preparation).

2.6. Regular Monitoring of the Programme and its Effectiveness

In addition to the use of tool outlined above, two other qualitatively-aligned tools have been applied to evaluate the classes:

1. A questionnaire for the evaluation of the programme at the end of their course, consisting of three open questions (what was the most useful? what was the least useful? what do I propose to change or include?)

2. Qualitative interviews conducted with five students of each class by open invitation. The interviews with participants of the course are conducted at the end of the course, are completely anonymous and voluntary. The subject of the interview focused on the problem (Rubacha 2008) is the spirituality program. Among the most important issue are the following:

   – What do you think about the spirituality classes in which you participated?

   - What is the meaning of the spirituality classes to you as a future doctor as well as in your private life?

   – What advantages and disadvantages could you see in the spirituality programme (what subjects were not discus enough and which ones should be excluded)?

   – In what way have the spirituality curriculum changed your view on spirituality?

   - Is this sphere important to you in human life and your work with the ill? In what way?

The interviews last about 30-45 minutes and with the agreement of the participants are recorded. After conducting the interviews with the students from all the groups the results will be analyzed according to grounded theory (Miles and Huberman 2000) and precisely presented in another publication.

3. Results. The Spirituality Programme at the Collegium Medicum in Bydgoszcz, Nicolaus Copernicus University in Torun

The overarching aim of our 'Spirituality in Medicine' programme was to provide medical students with knowledge about spirituality (broadly defined for the programme's purposes) and improve their competences in this area. The subjects taught during the classes as well as the expected learning outcomes correspond to the following objectives:

- To learn about spirituality as defined in the programme and how to refer this knowledge to one's own experiences, beliefs, and values;
- To learn about compassion in the context of spiritual care as a key aspect of interpersonal skills;
- To gain competence in diagnosing patients' spiritual needs and suffering;
- To learn how to provide help and spiritual support corresponding to the spiritual needs reported by patients (e.g. non-violent communication, interpersonal communication, mindful listening);
- To learn the requisite methods, techniques, and research tools to diagnose patients' spiritual needs and suffering;
- To learn about possible interventions and therapeutic methods that can be used when providing spiritual care to patients;

- To work on one's own spirituality in order to gain an insight into difficult and existential experiences;
- To be able to cooperate – as a physician – with a chaplain;
- To learn how to cope with death and dying, as well as how to help patients examine their lives, find a meaning and leave a spiritual legacy (e.g. elements of dignity therapy) (Chochinov et al. 2005; Brożek et al. 2019).

Table 1 provides a general outline of the program, highlighting in particular:

- The academic year for which a given module is intended;
- Topics to be discussed during the classes;
- The expected learning outcomes (depending on the overall approach to learning in each year).

Table 1. An outline of the obligatory programme of education in spirituality for medical students at the Collegium Medicum in Bydgoszcz, Nicolaus Copernicus University in Torun.

Table 1 here

Regardless of the number of teaching hours allocated to this subject, we wanted students to have the opportunity to gain similar knowledge and skills in all core aspects of spiritual care and spirituality. The amount of material covered varied depending on the time available for the respective thematic block. Classes were constructed in a manner that allowed us to discuss the similar main topics with every group of students, such as spirituality as a theoretical category, the ability to recognize spiritual suffering in a relationship with the patient, selected methods of intervention in situations of spiritual need and suffering, how to work on one's own spiritual development and reflect on one's own spirituality.

In order to achieve the intended aims and objectives and ensure expected learning outcomes, a number of teaching methods were proposed and implemented and have since been implemented during the classes. The most important of these are informative and thematic **lectures**, as well as seminars for a discussion of certain issues before practising them with students.

Other techniques employed during the classes (particularly as part of seminars and workshops) are as follows:

- **Excerpts from films, case studies, stories** – using various aids related to topics covered during the classes to apply the newly acquired knowledge and skills to concrete examples;
- **Role play, psychodrama** – to practise new skills;
- **Students sharing their own experiences** – in order to analyse their own emotions and experiences and thus better understand themselves while also highlighting possible reactions as well as the spiritual needs, suffering, and experiences of patients;
- **Didactic discussion** – a meta-analysis of problems addressed during the classes after watching a film or studying a case;
- **Students' own work based on a presented case study** – writing papers and attempting to use intervention techniques when working with a patient who has been diagnosed with spiritual needs or suffering;
- **Students sharing their experiences from practice** – based on direct contacts with patients (3rd, 4th, and 5th year students).

The first analyses of the interviews show that our classes were initially approached with reserve and reluctance. At the beginning, some students thought that the main aim of the programme

was to 'convert' them or 'discuss religion'. They had doubts about whether it really should be part of 'a doctor's work'. However, as the course progressed, they started to appreciate the variety of topics covered. With time they changed their minds and evaluated the course positively. Interviews clearly expressed their appreciation for the newly acquired skills. What they also found valuable was the fact that the classes presented them with different methods of diagnosing spiritual needs or suffering, conducting an intervention, and providing support[2].

The interviews with students participating in the classes indicate that students particularly enjoyed working on case studies and discussions based on films that dealt with the topics taught during the classes. Indeed, there was a belief that most of the issues covered during the course would prove useful in their future work, particularly in the case of students who plan to work with chronic disease patients.

Discussion

Teaching future physicians how to engage with spiritual care is essential for the development of whole person care medicine (Saunders 1964, 1993; Puchalski and Larson 1998; Harbinson and Bell 2015) According to its philosophy, physicians are not only „technically-competent" specialists in the specific branches of medicine, but compassionate persons accompanying other persons who are suffering, searching for the meaning, real hope, forgiveness, or closeness to God and/or other people (Puchalski and Larson 1998).

How physician builds the relation with the patients and the quality of their support depends not only on professional knowledge, but first of all on careful listening and hearing, compassionate presence and on better understanding of the experience of illness and suffering. To enable clinicians to play such a valuable patient and family-orientated role medical curricula should involve education directed to the improvement of the skills and competencies needed to address

[2] An analysis of the data obtained from the survey conducted at the end of the course and from the interviews with students will be presented in depth in another article (in preparation).

spiritual care (Osório et al. 2017). The program implemented at our medical university, the first distinct spiritual care curriculum in Poland, was designed to meet those expectations and to help future medical doctors to embrace whole person care in their practice.

The aims and objectives of our programme cited earlier are similar to those defined for the educational programs introduced at medical universities in USA, South America, UK and some other European countries (Puchalski and Larson 1998; Koenig 2007; Maar 2007; Leget 2012; Lucchetti et al. 2012; Lucchetti et al. 2012; Bennet et al. 2014; Paal et al. 2014; Baldacchino 2015; Harbinson and Bell 2015; Geer et al. 2016; Atkinson et al. 2018; Sajja and Puchalski 2018; Taverna et al. 2019; DeFoor et al. 2021; Wenham et al. 2021). These different spirituality curricula are generally focused on improving the student mindfulness, compassion and empathy, careful listening and communication on what is the most important, what is deeply inside the person, what he/she believes in, and hopes for. These also frame the starting point for the Polish curriculum. Thus, the programme is commensurate with international standards in the teaching of spiritual care as evidenced in our evaluation and in comparison with the literature. Similarly, the teaching methods and techniques included in our training on spirituality had been implemented successfully into some other medical universities in the world (Lucchetti et al. 2012; Bennet et al. 2014; Paal et al. 2014; Harbinson and Bell 2015).

Programs which concentrating on improving the ability to perform spiritual care are usually based on the case discussions, real patient history taking or self-reflective journaling (Wenham et al. 2021). These complement the more structured clinical knowledge achieved in a medical degree and are an important component of holistic mastery in clinical medicine. Thus education on spirituality should be at least partially included during the clinical years of studying medicine. As we monitor the efficacy of different options in the teaching of spirituality to medical students, we hope in a near future to assess whether it is better to teach spirituality every year, only at the beginning or just at the beginning and at the end of medical

studies.

A recent systematic review of international medical school and residency program curricula that address spiritual care pointed also to some other core content not included in our current spirituality curriculum, such as chaplain shadowing, teaching OSCE (Objective Structured Clinical Examination), simulated patients or spirituality dinners (Wenham et al. 2021). However our final evaluation how participation in the program change the students' knowledge and attitude to spiritual suffering and spiritual care for their patients will not be completed until next year. Based on this assessment we will consider potential changes in the program content.

Overall, we are in the process of improving education for medical students which has started to be opened for the whole person care approach to the people who are suffering (Anandarajah and Hight 2001). As until now the program on spirituality in medicine as a distinct curriculum is provided only in one medical university in Poland, the future analysis of its effects on students attitude and practice would help to define the role of such education.

Conclusions

Working with patients, particularly those with chronic diseases or at the end of life, shows that what they find important in a relationship with a healthcare professional does not simply come down to writing a prescription. When visiting the doctor, patients are burdened with their experiences and suffering. Accordingly, when they ask questions about their life and suffering, they want to see some meaning in what they are going through. They seek answers and have a need to talk about what is on their minds, even if these are challenging topics. It is essential to focus not only on their somatic symptoms. The WHO reports:

> 'Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to

beliefs and to faith – in healing, in the physician and in the doctor-patient relationship. This reductionist or mechanistic view of patients is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope, and compassion in the healing process' (WHO 1998).

The proposed programme of teaching spirituality to future doctors is the first educational project of this type in Poland which tries to meet this global ideal. It is our hope that this new curriculum will equip future doctors to respond sensitively and appropriately to the complex questions raised by illness, frailty and death.

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Table 1. An outline of the obligatory programme of education in spirituality for medical students at the Collegium Medicum in Bydgoszcz, Nicolaus Copernicus University in Torun.

Programme implemented in 2018/2019				
Form	2nd year	3rd year	4th year	5th year
	The overall approach to learning in each particular year			
	I get to know myself; I learn to be aware of my spiritual space	I can see the spiritual space of my patients; I learn to ask, listen, and hear, as well as to see and diagnose	I learn to help; I provide spiritual care to my patients, including cooperation with chaplain	I learn to cope with difficult situations when working with a patient who experiences spiritual pain while also taking care of myself; I learn to cope with (my patient's/my own) death
Lectures	4	4	-	-
Seminars	4	4	8	4
Workshops	4	4	4	8
Programme implemented in 2019/2020 and 2020/2021				
Form	2nd year			
	The overall approach to learning in this particular year			
	I get to know myself; learn to ask, listen, and hear, as well as to see and diagnose; I learn to help and provide spiritual support			
Lectures	10			
Seminars	6			
Workshops	6			
Programme approved for implementation from 2021/2022				
Form	2nd year		5th year (spirituality as part of the palliative medicine module)	

	The overall approach to learning in each particular year	
	I get to know myself; I learn to be aware of my spiritual space; I can see the spiritual space of my patients; I learn to ask, listen, and hear, as well as to see and diagnose	I learn to help; I provide spiritual support to my patients; I learn to cope with difficult situations when working with a patient who experiences spiritual pain while also taking care of myself; I learn to cope with (my patient's/my own) death
Lectures	4	-
Seminars	-	6
Workshops	6	6

Source: Authors' compilation.

‘Spirituality in Medicine’: A Training Programme for Medical Students in Providing Spiritual Care to Patients and Their Loved Ones. A Case Study from the Collegium Medicum in Bydgoszcz, Nicolaus Copernicus University in Torun, Poland

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Abstract:

Purpose: This article presents the first programme on spirituality in medicine for medical students in Poland implemented at the Collegium Medicum in Bydgoszcz of the Nicolaus Copernicus University in Torun.

Methods and materials: It identifies several steps needed for the development of the programme, including: preliminary work on the content of the programme, agreement on key concepts, terms, and definitions; consultations with coaches and teachers of spirituality in medicine from international centres; analysis of the available research and publications on teaching spirituality in other parts of the world; development of the first programme on spirituality for medical students, its implementation at the Collegium Medicum in Bydgoszcz and the monitoring of its efficacy.

Results: Step by step approach resulted in the introduction of first Polish spiritual curriculum for medical students which should in future lead to better care for sick people and improve the relationships between health care professionals and their patients.

Conclusion: The article presents the content of the program, the expected learning objectives and ascribed teaching methods, along with the preliminary evaluation made by students.

Declarations

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Conflict of interest: The authors declare no competing interests

Availability of data and material (data transparency)

The data are available in the author's archives.

Code availability – not applicable

Authors' contributions (optional: please review the submission guidelines from the journal whether statements are mandatory):

MFK and MK contributed to the creation and development of the program along to the process of its implementation and monitoring. PL and RG contributed to the preliminary work on the content of the program. MFK was responsible for the critical analysis of the literature on teaching spirituality in other parts of the world and for drafting the first version of the manuscript. MK was a coordinator of the program in the University. All authors were involved in critical analysis and interpretation of the study results and preparation of the final version of the manuscript.

Ethics approval (include appropriate approvals or waivers):

The project received the approval of the Ethics Committee of the Collegium Medicum of Nicolaus Copernicus University in Torun, Poland. The approval number is KB 736/2018.