AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: xxx
(X-23)

Introduced by: Academic Physicians Section (AMA-APS)

Subject: Spirituality in Medical Education and Practice

Referred to: Reference Committee __

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1 Whereas, Current AMA Policy H-160.900, "Addressing Patient Spirituality in Medicine," states,
2 "Our AMA recognizes the importance of individual patient spirituality and its impact on health
3 and encourages patient access to spiritual care services"; and
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5 Whereas, The term "spiritual care" does not require, yet does not exclude, the invoking of any
6 general or specific religious beliefs; rather, spirituality is broadly defined as seeking meaning,
7 purpose, and connectedness, and is inclusive of all ways people may understand spirituality in
8 their lives; and
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10 Whereas, Policy H-160.900 is silent as regards matters of spirituality as they would concern
11 physicians, physicians-in-training (to include resident/fellow physicians), medical students, or
12 other members of multidisciplinary health care teams; and
13
14 Whereas, Staff physicians, resident/fellow physicians, and medical students are all integral to
15 the patient care teams of academic medical centers, as well as other medical facilities, including
16 hospitals, outpatient clinics, nursing homes, and hospices; and
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18 Whereas, Our AMA's policies on diversity, equity, and inclusion note the need to respect people
19 and their diverse backgrounds, which applies specifically to the quality and equity of patient
20 care, in that members of medical care teams should demonstrate respect for the culture and
21 spirituality of the patient (and the patient's family); and
22
23 Whereas, Many health organizations, including the World Health Organization (WHO), via its
24 Resolution on Palliative Care, have noted the need to for prevention and relief of suffering by
25 means of early identification and correct assessment and treatment of pain and other problems,
26 whether physical, psychosocial, or spiritual; and
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28 Whereas, The treatment of all severe pain, including spiritual pain, is a human right, according
29 to the WHO's "Resolution on Palliative Care"[1]; and
30
31 Whereas, Clinicians working or learning at academic medical centers provide care to many
32 patients who are burdened by diseases that may be rare, complex to manage and/or
33 multifactorial in nature, as well as patients experiencing crises, trauma, and end-of-life, such
34 that the prevalence of spiritual distress is high in these patients and generally worsens in
35 parallel with increasing physical symptom intensity and/or severity[2]; and
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37 Whereas, Many patients burdened by such diseases or situations value clinicians who integrate
38 inquiry about patients' spirituality as related to their health, and benefit from access to specialist
39 spiritual care services, when such access is enabled for them; and
40

Whereas, A Delphi review of the literature found sufficient evidence to recommend education on spirituality and health in the care of patients with serious and/or chronic illness[3]; and

Whereas, Patient referral and access to spiritual care services at medical centers would be enhanced by all physicians and medical students learning how to provide generalist spiritual care through the assessment and treatment of spiritual distress as a clinical symptom, with treatment options to include compassionate listening and presence to patients' suffering, reflective inquiry to enable patients to fully express their spiritual distress, referral to and collaboration with spiritual care specialists, and continued follow up with the patient on spiritual issues as indicated; and

Whereas, Instruction in medical education regarding spiritual health as part of whole person care, assessment, and treatment of spiritual distress could be expected to enhance "emotional intelligence" and the recognition of opportunities for either providing spiritual care or referring the patient to a spiritual care specialist; and

Whereas, Burnout—a condition characterized by feelings of pervasive energy depletion or exhaustion, negativism or cynicism about one's occupation or occupational role, and/or a sense of inadequacy or ineffectiveness in one's occupational role, is a pervasive emotion and state among clinicians and clinicians-in-training; and

Whereas, Spiritual distress can contribute to burnout across the continuum of medical education and practice, with an association between increased burnout and decreased meaning in work, while the practice of spirituality may be a protective factor against burnout, with such interventions as "reflection rounds" helping health professionals and students rekindle their sense of meaning in their chosen vocation[4]; and

Whereas, It is therefore reasonable to hope that by providing physicians and physicians-in-training with opportunities to become more well-educated regarding matters of spirituality, and by enabling them to implement a spiritual approach to their own life and life stresses—including use of spiritual resources such as meditation, seeking professional spiritual care if needed, and/or finding a spiritual community of support—that these individuals may be favorably impacted and be less susceptible to burnout; and

Whereas, By extension, increased knowledge and awareness of spiritual principles may enhance the abilities of caregivers to not only provide more effective care to others, but also to provide more effective self-care to themselves; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-160.900 to read as
2 follows:
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4 **Spirituality in Medical Education and Practice**
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6 Our AMA encourages the inclusion of spiritual health in curricula in medical school,
7 graduate medical education, and continuing physician professional development as an
8 integral part of whole person care. Curricula should include:
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10 1) assessing spiritual health as part of the history and physical;
11 2) addressing treatment of spiritual distress by the clinician, with appropriate referral to
12 spiritual care professionals;
13 3) acknowledging patients' spiritual resources;
14 4) developing compassionate listening skills;
15 5) ensuring ongoing follow up of patient's spiritual health by clinicians as appropriate;
16 6) understanding ethical guidelines on communication with patients on spiritual issues;
17 and
18 7) self-reflection on one's own spirituality within professional development courses,
19 especially as related to their vocation and wellbeing. (Modify HOD Policy)

Fiscal Note: Minimal

Received: TBD

RELEVANT AMA POLICY

Addressing Patient Spirituality in Medicine H-160.900

Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services. (Res. 004, I-16)

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[1] World Health Organization. Strengthening of palliative care as a component of integrated treatment within the continuum of care. Adopted as a Resolution by the World Health Organization; Geneva, Switzerland: May 2014.

[2] Cipta, A, Turner, B., Haupt, E. et al. Spiritual distress: symptoms, quality of life and hospital utilisation in home-based palliative care. *BMJ Supportive Palliative Care* 2021 Sep;11(3):322-328. doi: 10.1136/bmjspcare-2021-003090. Epub 2021 Jun 4.

[3] Balboni, T, VanderWeele, T, Doan-Soares, et al. Spirituality in Serious Illness and Health. *JAMA* 2022;322:184-197.

[4] Wachholtz A, Rogoff M. The relationship between spirituality and burnout among medical students. *J Contemp Med Educ*. 2013;1:83-91.