Australian doctors' perspectives on spiritual history-taking skills

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Abstract

Introduction: This original research examined the experience of Australian doctors using spiritual history-taking skills in holistic medical consultations and evaluated the support of Australian doctors for education on spiritual history-taking skills.

Methods: General practice registrars and post-registrar graduate doctors, sourced primarily from the Hawkesbury Nepean region within NSW, Australia, completed an online survey. Excel data analysis tools were applied to analyse the quantitative results obtained. Line-by-line coding and manual analysis were applied to the free-text answers.

Results: The survey was completed by 147 doctors practising medicine in Australia, a response rate of 24%. Registrars or residents-in-training accounted for 46%; 53% were post-registrar general practitioners. Most doctors (91%) recognised that spiritual care had some role in holistic medical care. Spirituality was included in medical consultations at least occasionally by 47% of doctors. However, only 21% felt confident with including spiritual history. Key barriers were insufficient time, lack of knowledge and lack of skills. Key facilitators included understanding other world views, knowledge of religions, awareness of own beliefs and basic communication skills. Spiritual history-taking skill education for all doctors was supported by 75%.

Conclusions: The majority of Australian doctors who participated in this survey acknowledged the importance of spiritual history within holistic medical care, and many are incorporating this into their regular practice. Yet most doctors recognised a lack of knowledge and skills and desired further training, especially in spiritual history-taking skills. Inclusion of this in Australian medical education was strongly supported.

Keywords: Australian; doctor; spiritual; education.

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Introduction

The spiritual aspect of health has received increased attention over recent years as medicine strives to embrace a bio-psycho-socio-spiritual model of healthcare. One systematic review of 54 studies evaluating patient preferences clearly indicated the majority of patients desire some consideration of spirituality in their medical consultations and health management (Best, Butow, & Olver, 2015b). The Australian patient study included in that review concluded that patients do not desire spiritual inquiry in order to receive spiritual guidance but to build a stronger relationship in which they can receive holistic care (Best, Butow, & Olver, 2014). However, although the majority of physicians agree that spiritual wellbeing is important to health, very few actually ask about it (Best et al., 2015b).

Recognition of the patient priority for spirituality to be incorporated into healthcare management addresses only part of the holistic medicine equation. The current attitudes and skills of Australian doctors must also be identified, and any gaps between patient preference and doctor capacity recognised and addressed.

Research in the area of spirituality within medicine has been heavily focused on the American experience, with the majority of information reflecting American culture (Best et al., 2015b; Best, Butow, & Olver, 2016). Since 2007, the Association of American Medical Colleges has recommended inclusion of spiritual care in the medical school curriculum and has developed learning objectives for these courses (The George Washington Institute for Spirituality & Health, n.d.). By 2012, over 100 medical schools in America had incorporated spirituality in their medical curricula—vastly different from Australian medical schools.

With interest in developing base criteria for incorporating spiritual history components into the Australian medical curriculum, data is vital in ensuring that resources and priorities reflect the Australian need. A review of the webpages and curriculum information available in 2015 for the Australian medical schools that listed a spiritual care subject (19 schools) found only one had a full subject in spirituality and health (University of Sydney), and only one provided practical skills training in spiritual history taking as a compulsory component of the curriculum (University of Notre Dame Australia, Sydney). The other medical schools included optional sessions on comparative spirituality or included spirituality within complementary medicine, stress management, end-of-life care, aged care or palliative medicine modules. In comparison, by 2012, 59% of British medical schools and 90% of US medical schools included content on spirituality and health (Lucchetti, Lucchetti, & Puchalski, 2012).

Since 1998, the World Assembly of Health has included spirituality as a component of health, affirming that "health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity" (WHO, 1947). Since 2009, the Medical Board of Australia has supported this definition as well, stating:

> Good medical practice is patient-centred. It involves doctors understanding that each patient is unique, and working in partnership with their patients, adapting

ISSN 1442-1100

> what they do to address the needs and reasonable expectations of each patient. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services. (Medical Board of Australia, 2014)

The varying definitions of "spirituality" within healthcare have complicated attempts to collate and compare the literature available. To enable the focus of this study to remain on spiritual history-taking skills, regardless of the specific spiritual perspective of the respondent, we considered the following broad definition of spirituality most appropriate for this research in the Australian context.

> Spirituality is a complex and multidimensional part of the human experience which includes the personal search for meaning, purpose and truth in life, and the beliefs and values by which an individual lives. It involves feelings of hope, love, connection, inner peace, comfort and support. The spiritual journey into meaning usually involves self-transcendence (Anandarajah & Hight, 2001; Best et al., 2014; D'Souza, 2007; Koenig, 2008; Siddall, Lovell, & MacLeod, 2015)

The spiritual history is that component of a holistic patient-focused medical consultation in which the clinician enquires about beliefs, behaviours and support systems that may influence the patient's medical care.

A 2015 systematic literature review aimed to improve understanding of the mismatch between expressed intentions and actual practice isolated 61 articles that focused on the doctor's engagement with spirituality within the medical consultation (Best et al., 2016). The USA was the source of 41 of the 61 studies. Only three of the studies originated in Australia, each containing very small numbers (23 doctors, 15 doctors and 15 patients, respectively), and all were in the context of palliative care (Best et al., 2014; Best, Butow, & Olver, 2015a; Kelly et al., 2008). This reflects the current status of research into this topic.

A systematic review on the global status of spirituality within medical education by Lucchetti, Lucchetti and Puchalski (2012) was not limited to English publications, yet they still found 81.5% originated in the USA, 7.8% in Canada and only 10.5% outside of North America. Without further research encompassing other languages, cultures and religions, it is difficult to determine if the results from the studies (mostly originating from the USA) are transferable, replicable or relevant in other environments.

Best, Butow and Olver (2016), in their systematic literature review, found that specific clinically-focused training for doctors in discussing religion/spirituality was the strongest predictor of discussions and provision of spiritual care. Diverse potential barriers were explored, concluding that insufficient time, personal discomfort, lack of training, lack of "spiritual" vocabulary and professional boundary concerns all restricted doctors' engagement with spirituality within medical consultations. Many physicians expressed a preference for chaplain referral for spiritual discussions, even if related to health decisions.

ISSN 1442-1100

Physician characteristics were also examined. Primary care, psychiatric and palliative care physicians were more likely to incorporate spirituality into the medical consultation. Age and racial background did not affect the likelihood of spiritual discussions within consultations in that primarily American database.

Consideration of the ethnic compositions of America and Australia demonstrate significant differences in cultural composition (AAMC, 2006, 2010; HWA, 2012; Young, 2011). However, differences in religious affiliation (Table 1) do not support claims that Australians are less religious than Americans (Peach, 2003).

Table 1
American/Australian Religious Affiliation

Religious Affiliation	America 2015[1]	Australia 2011 Census[2]
Christian	70.6%	61.1%
Buddhist	0.7%	2.5%
Islam	0.9%	2.2%
Hindu	0.7%	1.3%
Judaism	1.9%	0.5%
Other	1.8%	10.1%
No religious affiliation	23.4%	22.3%

1 PRC, 2015
2 Australian Bureau of Statistics, 2011

The views of Australian medical school deans on the inclusion of spirituality components in the medical curriculum are currently being studied by a West Australian group (A/Prof Kellie Bennett) with a John Templeton Foundation grant. This creates an imperative that the experience and opinions of Australian doctors are heard and evaluated. The following research questions were developed to enable such an evaluation:

1. What has been the experience of Australian doctors with using spiritual history-taking skills as part of holistic medical histories and care?
2. What do Australian doctors perceive as the most significant facilitators and barriers to inclusion of spiritual history taking within a comprehensive patient history?
3. Do Australian doctors support inclusion of education on spiritual history-taking skills for all medical students and graduates? If so, what do Australian doctors consider the most important components of such education?

Methods

The published studies considering the Australian perspective to date have included very small numbers of participants, resulting in limited ability to extrapolate findings to the greater Australian context. For this study, an electronic survey was developed using a combination of components of surveys used in primarily American, British and multinational populations (Best et al., 2015b; The George Washington Institute for Spirituality and Health, n.d.; Harbinson & Bell, 2015; Puchalski & Ferrell, 2010;

ISSN 1442-1100

Ramondetta et al., 2013). This intentional commonality was to enable some comparison of responses in the Australian context with those reported in other areas of the world. Approximately 850 doctors currently practising within the Australian health system were invited to participate through a hyperlink in an electronic newsletter—approximately 350 doctors within the Nepean Blue Mountains Primary Health Network region and 275 doctors within the GP Synergy (general practice training) network. Two weeks after release of the e-newsletter, an email invitation was sent. A total of 147 unique doctor contributions were received, corresponding to a response rate of 24%.

The survey was designed to be completed anonymously. A participant information sheet that explained the survey in plain English was provided. Consent to participate was assumed by the submission of a completed survey. Ethics approval (number 016059F) was granted by the Human Research Ethics Committee at the University of Notre Dame Australia.

The majority of data on dependent variables and independent variables was captured using dichotomous and Likert-style rating scales (see Appendix), providing quantitative data for statistical analysis to investigate trends in the study population and exploration of possible association between variables. Excel data analysis tools were applied to analyse the quantitative results obtained. Open-ended questions were also included in the survey to elicit more nuanced narrative responses from each respondent, and so yield further contextual information to complement and enhance the validity and meaningfulness of the quantitative data. Line-by-line coding and manual analysis have been applied to the free-ext answers, providing richness and depth to the understanding of the relationships identified with the quantitative analysis.

Results

The survey was completed by 147 doctors currently practising medicine in Australia. Of these, 46% were registrars or residents-in-training (Reg/RMO) and 54% were post-registrar general practitioners (GP). Percentages stated below are based on this sample size. Table 2 summarises the demographic data of the survey participants. Note that 55% of Reg/RMO were under 30 years old, while 31% of GPs were over 50 years old, with only 21% under 30 years old.

Respondents were asked to indicate personal beliefs, with an option of "prefer not to answer". Six respondents chose not to answer. Of the remainder, over 60% (with no significant difference between reg/RMOs and GPs) believe in life after death (63%) or believe in God (65%). The relative weighting of respondents' religious affiliations (52% Christian, 15% other, 35% no religion) reflected the general Australian population. The Australian census data (2016) reports 52% of the population as Christian, 8.2% as another religion and 30.1% with no religious affiliation.

ISSN 1442-1100

Table 2
Demographic Results: Australian Doctors and Spiritual History-Taking Skills, Australia 2016

Primary Area of Work	**% of Total**		
Reg/RMO	46		
GP	54		
Age		**% of Reg/RMO**	**% of GP**
< 30 years	28	55	21
30–50 years	45	42	48
> 50 years	18	3	31
Ethnicity			
Born in Australia	61	64	57
Born outside Australia	39	36	43
Countries of birth		Canada, England, India, Iraq, New Zealand, Philippines, Singapore, South Africa, Sri Lanka, Taiwan, USA	Bangladesh, China, England, Hong Kong, India, New Zealand, Papua New Guinea, Saudi Arabia, South Africa, Sri Lanka
Ancestry			
United Kingdom or Irish	35	34	36
Non-Aboriginal Australian > 3 generations	19	19	20
Australian indigenous	2	4	0
Other	44	43	44
Other ancestry		African, Chinese, European, Indian, Iraq, Italian, Sri Lankan, Taiwan, UK/Ireland, USA, Vietnamese	Chinese, European, German, Indian, Italian, Pakistani, Polish, Portuguese, UK/Ireland
Country of Graduation			
Australia	88	96	80
Other	12	4	20
Graduation countries		China, Philippines	Bangladesh, India, New Zealand, Pakistan, South Africa, United Kingdom
Years Practising Medicine			
0 – 5 years	55	81	33
6 – 20 years	23	15	30
> 20 years	22	4	37
Religious Affiliation			
Christian	52	47	52
Other than Christian	15	17	17
Other religions		Buddhist, Hindu, Islam, Sikhism	Buddhist, Hindu, Islam
No religious affiliation	35	36	31

ISSN 1442-1100

Table 2
Demographic Results: Australian Doctors and Spiritual History-Taking Skills, Australia 2016 (contd.)

Personal Belief			
Believe in God	65	61	69
Believe in a higher power other than God	21	24	19
Believe in more than one god/higher power	9	7	10
Believe in life after death	63	60	65

Experience with education in spiritualty as a component of holistic healthcare

Of the doctors who completed this survey, 53% had received some education in spirituality as a component of holistic healthcare at some stage in their career. Medical school was the source for 76%, with 49% of all Reg/RMOs and 33% of all post-registrar GPs having encountered this education during medical school. Only 17% of Reg/RMOs and 8% GPs reported receiving this type of training during their RMO/registrar years. The vast majority of these doctors working in Australia studied medicine in Australia (88%).

The nature of any instruction on spirituality within health was most commonly lectures, seminars and tutorials, especially within palliative care, Aboriginal health and ethics. Self-directed reading was significant for many. Small numbers of doctors gained this education through conferences or colleague mentors. Education content was primarily cultural and spiritual beliefs and behaviours. Only 35% had ever received training in skills for including spiritual history in medical consultations; 69% of these doctors encountered this education during medical school, 18% during their registrar years and 13% in their post-registrar years.

This pattern of primarily medical school exposure was repeated when considering other topics of education—the impact of spirituality on health outcomes, the potential contributions of the clergy/spiritual leaders within a multidisciplinary health team and understanding your own spirituality. Through the free-text response option, a small number of respondents described life experience or their own church/faith community as their key source of education on these topics.

Experience with inclusion of spiritualty within medical consultations

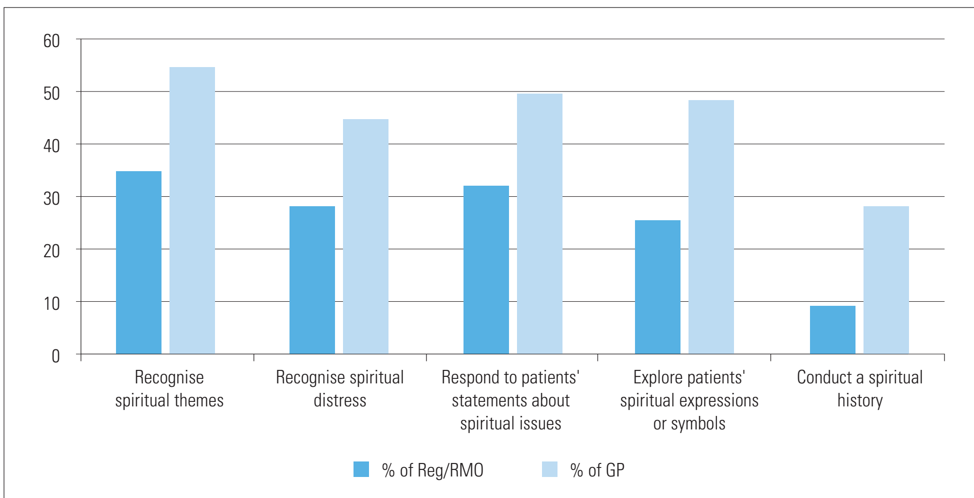
Most doctors practising in Australia recognised that spiritual care had some role in holistic medical care (91%). This was considered a very important role by 25% of Reg/RMOs and 57% of post-registrar GPs. The perceived importance increased as the doctor's age increased—only 23% of doctors aged less than 30 years considered this very important compared with 62% of doctors aged over 50 years. Likewise, the perceived importance increased the longer the doctor had been practising medicine—30% of doctors less than 5 years from graduation considered this important, whereas 72% of

ISSN 1442-1100

doctors who had been working in medicine for over 20 years considered the spiritual aspect of holistic care very important.

Considering discussions on religion or spirituality with patients, 47% of respondents had discussions more than once in any 6-month period—40% Reg/RMOs and 62% GPs. These discussions occurred often (at least once in any 2-month period) with 13% of Reg/RMOs and 23% of GPs. Only 19% of respondents felt confident to take a spiritual history as part of a patient medical history. Overall, a smaller percentage felt confident than the number who were actually engaging in these conversations, and in every subset, more GPs expressed confidence than Reg/RMOs. Only 9% of registrars felt confident to take a spiritual history (Table 3).

Table 3
Confidence in Including Spirituality Within the Medical Consultation, Australia 2016



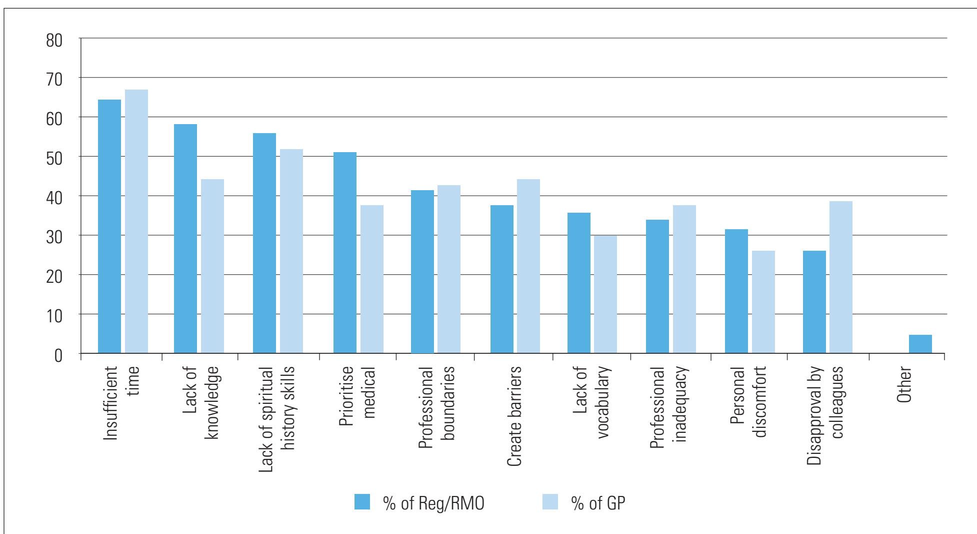
Both the Reg/RMO and the GP groups considered the patient's spiritual leader and their family as the two most appropriate spiritual carer resources for a patient who has disclosed a health-related spiritual need. Spiritual leaders were rated as the most appropriate by 89% of doctors and 68% rated the family as most appropriate. Both respondent groups considered the doctor more appropriate than either nurses or community workers as spiritual carer for patients. However, more GPs (46%) saw the doctor as an appropriate person to provide this care than Reg/RMOs (28%). Both groups rated access to faith community and access to chaplain/spiritual leader as the most important interventions when a spiritual need is identified.

ISSN 1442-1100

Facilitators and barriers

All doctors valued the same facilitators, with no significant difference between Reg/RMOs and GPs. The key factors that facilitated engagement in discussions on spirituality with patients included understanding other world views (97%), knowledge of religions (93%), awareness of own beliefs (83%) and training in basic communication skills (71%). Both the Reg/RMO and GP groups identified fairly similar key barriers—insufficient time, lack of knowledge and lack of skills (Table 4).

Table 4
Perceived Barriers to Spiritual Discussions Within Medical Consultations, Australia 2016

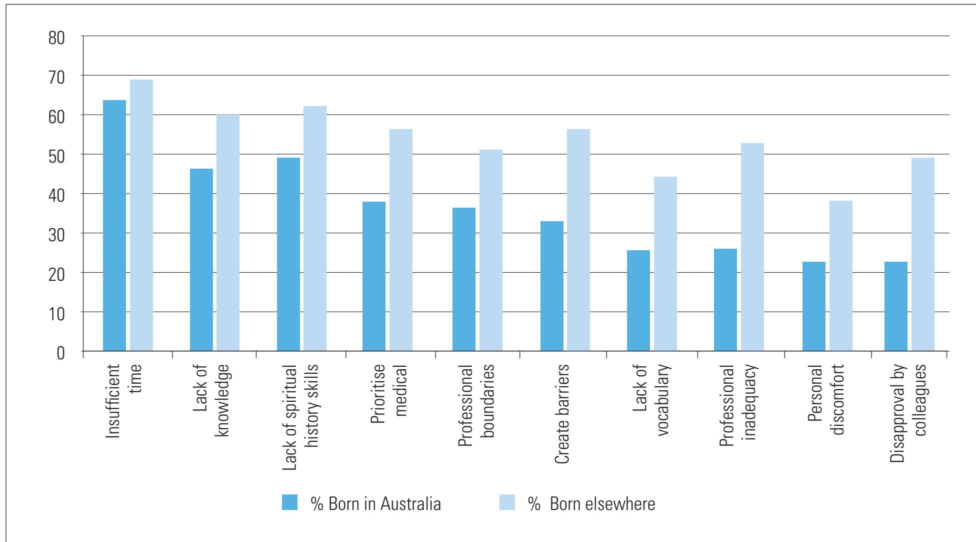


Lack of spiritual history-taking skill training was the key reason described in free-text responses for lack of confidence in taking a spiritual history (45% of those who lacked confidence). Lack of knowledge and understanding was the most significant barrier to doctors recognising spiritual distress or suffering during a patient encounter. The doctors who had been born outside of Australia were more likely to identify barriers (Table 5), with more than 50% of these doctors (n = 45) identifying additional significant barriers. These barriers included the belief that the consultation should prioritise physical and psychological concerns, the concern that a barrier may be created in the therapeutic relationship if the doctor and patient have different belief systems and the fear of professional inadequacy if significant problems are raised.

The interest in training specifically in spiritual history-taking skills was strong, with 75% favouring this. This included support from 59% of doctors with no religious affiliation. The same number supported the inclusion of spiritual history-taking skill training in the medical curriculum for all medical students. Communication skills

ISSN 1442-1100

Table 5
Perceived Barriers to Spiritual Discussions Within Medical Consultations, by Birthplace of Doctor, Australia 2016



specific to spirituality, spiritual history-taking skills for use within medical consultations, multicultural and spiritual beliefs and behaviours, and the impact of spirituality on health outcomes were all considered high priority inclusions for education by over 70% of respondents.

Discussion

Spirituality is fundamental to the practice of holistic medicine, so engaging with this topic demonstrates respect for all people, and especially for cultural diversity. Australia has a reputation for cultural and religious diversity. The doctors invited to participate in this survey lived and worked in a region with cultural, religious and socio-economic variances similar to that of the wider Australian population, according to the most recent census data. The demographic variation of the respondents also reflected Australian variations, despite the voluntary nature of the survey. This increases the likelihood that these results may be representative of the greater Australian medical experience. Respondents were in the field of general practice or in general practice training. As the only other studies of Australian doctors have been in the palliative care setting, this research provides important insight into the application of holistic medicine across the stages of life, healthcare needs and the variety of medical disciplines that are encountered in primary care medicine.

ISSN 1442-1100

The experience of Australian doctors using spiritual history-taking skills in holistic medical care

Australian doctors overwhelmingly recognise the inclusion of spirituality in the medical history as an important aspect of holistic healthcare in the 21st century. The importance attributed to spiritual care within the consultation increased as the doctors career lives progressed, with the majority of doctors more than 6 years into their medical career seeing this as more than occasionally important.

Almost two thirds of Australian GPs include aspects of spiritual care in the medical consultation. Yet many of these same doctors indicated that they lacked confidence. The gap between practice and confidence was most marked when considering spiritual history-taking skills, with only 9% of Reg/RMOs expressing confidence despite 40% including some form of spiritual history taking within the medical consultation across any 6-month period. GPs expressed a similar gap between practice and confidence. While 62% of GPs incorporated discussion of spirituality in the healthcare context at least occasionally, only 19% expressing confidence in the spiritual history aspect of the consultation.

Once a spiritual need has been identified, the majority (80%) of Australian doctors considered referral to a chaplain/spiritual leader and access to the patient's faith community as the most appropriate interventions. The doctor was considered to have an intermediate role, more than either nurses or community workers—perhaps a reflection of the immediacy of the doctor–patient relationship when the need is disclosed. This is quite different to the reported approach from studies of American doctors, where 5–42% would recommend chaplain referral (Best et al., 2016).

The declared experience of Australian doctors in this study does not support the conclusion that reported associations between religiosity and health may not be relevant to Australia (Peach, 2003). It appears that Australian doctors rate the spiritual aspect of holistic healthcare as more relevant than their American colleagues. The American experience is that 16–32% of doctors ask about spiritual need within the health context (Best et al., 2016), whereas this survey reports enquiry by 47% of Australian doctors.

Significant facilitators and barriers to inclusion of spiritual history taking in the medical consultation

Barriers to inclusion of spiritual history components in the holistic medical consultation were similar to those identified in other regions of the world—insufficient time, lack of knowledge and lack of skills. Best et al. (2016) noted barriers that were identified in 36 of the studies in their systematic review; most prominent were "insufficient time" and "personal discomfort", which included lack of knowledge, training and clarity regarding roles. Australian doctors in this sample represented 17 diverse ethnic groups. This multicultural diversity is a hallmark of the Australian community. Those born overseas identified greater concerns around the professional appropriateness of spiritual discussions. The majority of doctors lacked confidence across all areas of spiritual

ISSN 1442-1100

history taking within the medical context. Of those who lacked confidence, the most consistent significant underlying factor was the lack of spiritual history-taking skills.

Those who had engaged in spiritual discussions rated specifically-focused clinical skills training as the key facilitator. This was in alignment with the expressed facilitators from international studies—43 papers in the systematic review by Best et al. (2016) reported prior skills training as the strongest predictor of engagement with spiritual discussions.

Support for education on spiritual history-taking skills for medical students and graduates

The majority of Australian doctors in this study supported inclusion of spiritual history-taking skills in the compulsory curriculum for all medical students, and the same number expressed interest in participating in further education. One third had already done some training in spiritual history taking. This research has shown that the vast majority of doctors believe this is an important aspect of the holistic medical consultation, however a smaller number are attempting to incorporate the spiritual component in their patient history, and most of these lack confidence in this aspect of their consultation skills.

The most significant gap between skills (lacking) and practice was seen among Reg/RMOs. As the main source of instruction in spiritual aspects of holistic healthcare has been medical school, it appears that there is an immediate need to provide skill training for doctors within the first 5 years after graduation. The three key priorities of (a) multicultural and spiritual beliefs and behaviours, (b) the impact of spirituality on health outcomes and (c) communication and spiritual history-taking skills are worth consideration when reviewing medical school curriculums. Although an awareness of personal beliefs was important in increasing doctor capacity to engage in spiritual conversations, this was rated the least important topic for inclusion in formal medical education.

The Association of American Medical Colleges has endorsed learning objectives for American medical schools, with high priority on the ability to elicit a spiritual history (The George Washington Institute for Spirituality & Health, n.d.). Although developed to address the perceived need by American doctors, these may provide a useful guide to addressing the similar needs expressed by the Australian doctors in this study.

Limitations

The possible threat to external validity of findings due to non-response error in a survey research design is acknowledged. The impact should not be significant in this exploratory study of a currently uncharted terrain in the context of Australia. The focus of analysis and findings from this study has been on descriptive statistics to provide a profile of the current landscape and trends pertaining to the target area of investigation.

The survey was completed voluntarily. It is possible that those doctors with a favourable bias towards spirituality in healthcare participated, creating an overestimation of the

ISSN 1442-1100

importance of this aspect to medical consultations and educational need. This bias may be true compared with the greater doctor population. Yet if this group, who may practise spiritual history inclusion more frequently than their non-participating colleagues, felt a lack of knowledge and skills, it is reasonable to think that colleagues with less desire to include spirituality may have a greater deficit of knowledge and skills. The demographics of the doctors sampled were not more "religious" than the Australian population.

Conclusion

In the current global healthcare environment, and with a multicultural Australian community, it is important to expand understanding beyond the American, primarily Judeo-Christian, experience and to identify the training desired by the Australian medical community to enable appropriate spiritual discussions within medical consultations.

Surveying 147 Australian doctors, this research has determined that spiritual history is viewed as an important, relevant aspect of holistic healthcare in the Australian context. The majority of participating doctors desire further training in spiritual history-taking skills and support the inclusion of specific education for all medical students and graduates. The numbers of doctors who incorporate some manner of spiritual discussion in their patient consultations significantly exceeds those who feel confident with their skills in this area. Registrars-in-training and resident doctors have the greatest gap between skills and practice, revealing a need to develop specific education directed towards this group. Although there is some inclusion of spirituality in some Australian university medical education, this has not adequately prepared Australian doctors for application of the skill within their medical consultations. The perceived barriers and facilitators are similar to those identified in previous studies of primarily American doctors. Thus, the programs that have been developed and used in the American environment have relevance in guiding curriculum-planning decisions and the development of spiritual history modules appropriate for the Australian context.

As this is the first study specifically identifying the priorities of a significant sample of Australian doctors, the outcomes of the survey will also inform further questions and provide a basis for further research in the spiritual history component of holistic medicine.

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ISSN 1442-1100

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ISSN 1442-1100

Appendix

Australian Doctors' Perspectives on Spiritual History-Taking Skills Survey

1. Have you received instruction in spirituality as a component of holistic healthcare?
   i. During medical school?
   ii. During residency or registrar training?
   iii. During continuing professional development post-registrar training?
2. Did any of the instruction you have received in spirituality as a component of holistic health include the following topics?
   i. Skills for including the spiritual history in the medical consultation
   ii. Education about varying cultural and spiritual beliefs and behaviours
   iii. The impact of spirituality on health outcomes
   iv. The potential contributions of the clergy/spiritual leaders within a multidisciplinary health team
   v. Understanding of your own spirituality
3. Briefly describe the nature of any instruction on spirituality within health that you have received.
   i. Formal teaching (e.g., lectures, tutorials etc)
   ii. Informal teaching or mentoring
   iii. Self-directed reading / seminars
   iv. Other
4. Do you consider spiritual care an important component of holistic medical care?
   Please rate your opinion on the scale below:
   Not important; rarely important; occasionally important; more than occasionally important; quite important; very important
5. In your own practice, have you ever engaged in a discussion on religion or spirituality with patients?
   No – go to Question 7
   Yes, but rarely (less than twice in 2 years);
   Yes, occasionally (at least once in any 6-month period)
   Yes, often (at least once in any 2-month period).
6. If yes, please indicate which of the factors below increased your ability to engage in these discussions:
   i. Receiving training in basic communication skills
   ii. Having an awareness of your own personal beliefs
   iii. Having an understanding of other world views

ISSN 1442-1100

iv. Having knowledge of different religions and practices

v. Consulting with trained chaplains or spiritual leaders before, during or after the patient discussion

vi. Receiving specific training in skills to recognise spiritual issues

7. Concerning your confidence in including spirituality within the medical consultation ...

   i. Do you feel confident to recognise spiritual themes during a patient encounter?

   ii. Do you feel confident to recognise spiritual distress or suffering during a patient encounter?

   iii. Do you feel confident to respond to patients' statements about spiritual, religious or existential issues?

   iv. Do you feel confident to explore patients' spiritual expressions or symbols (such as religious jewellery, clothing or literature)?

   v. Do you feel confident to conduct a formal spiritual history as part of a comprehensive patient history (e.g., on admission)?

   vi. If no, please explain the key reasons you do not feel confident.

8. In your opinion, who should provide care for a patient who has disclosed a spiritual need affecting their health outcomes?

   Doctor; nurse; community worker; counsellor; psychologist; family; spiritual leader, e.g., priest/minister; other

9. In regard to spiritual care for patients' health outcomes, please rate how important you consider each of the following:

   Counselling; sacred music/songs; religious rites/ceremonies; healing services; access to a chaplain or spiritual leader; access to a sacred text or other reading; prayer/spiritual intercession; contact with own faith community; other

10. Research in other countries has identified the following reasons why doctors might NOT be engaging in spiritual discussions within the medical consultation?

    Please rate how significant each of these have been as barriers in your personal experience?

    Insufficient time; lack of knowledge about spirituality within health; lack of skills in discussing a spiritual history; fear of professional inadequacy if significant problems are raised; personal discomfort with discussing spiritual matters; lack of appropriate vocabulary to discuss spirituality; belief that spiritual discussions may violate professional boundaries; concern that a barrier may be created if the doctor and patient have different belief systems (detrimentally affecting the therapeutic relationship); concern that colleagues or the medical institution may disapprove or oppose such discussions; belief that the consultation should prioritise medical (physical and mental health) concerns

ISSN 1442-1100

11. Would you be interested in receiving further training in spiritual history-taking skills that are specifically appropriate for the medical consultation?
12. Do you believe spiritual history-taking skills should be included in the curriculum for all medical students?
13. If yes, (i.e., you believe spiritual history-taking skills should be included in the curriculum for all medical students) what priority would you recommend for each of the possible components suggested below?
    i. Spiritual history-taking skills for use within medical consultations
    ii. Multicultural and spiritual beliefs and behaviours
    iii. Cultural and spiritual beliefs associated with end-of-life only
    iv. The impact of spirituality on health outcomes
    v. The role of the clergy/spiritual leaders in a multidisciplinary health team
    vi. Understanding of your own spirituality
    vii. Communication skills specific to spirituality

14–22. Demographic data: to religion, religious practices, personal beliefs, age, country of birth, ancestry, country of graduation, years in medicine, area of medical work

ISSN 1442-1100