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## INCORPORATION OF SPIRITUAL CARE AS A COMPONENT OF HEALTHCARE AND MEDICAL EDUCATION: COMPARISON OF VIEWPOINTS OF HEALTHCARE PROVIDERS FROM A RURAL COMMUNITY HOSPITAL IN UGANDA WITH THOSE OF MEDICAL STUDENTS FROM THE UNITED KINGDOM

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### ABSTRACT

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*This study addresses cultural differences regarding views on the place for spirituality within healthcare training and delivery. A questionnaire was devised using a 5-point ordinal scale, with additional free text comments*

*assessed by thematic analysis, to compare the views of Ugandan healthcare staff and students with those of (1) visiting international colleagues at the same hospital; (2) medical faculty and students from a region of United Kingdom. Ugandan healthcare personnel were more favourably disposed towards addressing spiritual issues, their incorporation within compulsory healthcare training, and were more willing to contribute themselves to delivery than their European counterparts. Those from a nursing background also attached a greater importance to spiritual health and provision of spiritual care than their medical colleagues. Although those from a medical background recognised that a patient's religiosity and spirituality can affect their response to their diagnosis and prognosis, they were more reticent to become directly involved in provision of such care, preferring to delegate this to others with greater expertise. Thus, differences in background, culture and healthcare organisation are important, and indicate that the wide range of views expressed in the current literature, the majority of which has originated in North America, are not necessarily transferable between locations; assessment of these issues locally may be the best way to plan such training and incorporation of spiritual care into clinical practice.*

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**KEYWORDS:** Medical education, United Kingdom, Uganda, Whole-person care

## INTRODUCTION

**H**ealth is defined by The World Health Organization (WHO) as a state of “complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>1</sup> Addition of a spiritual dimension to this definition has been advocated<sup>2</sup>, reflected in recent quality of life questionnaires.<sup>3</sup> Spirituality is defined as “personally held beliefs, values, and practices” and “awareness of the ultimate meaning and purpose of life”. Spirituality may be associated with, but should be differentiated from, religion or religiosity, which imply “an expression of spiritual belief through an organized system of rituals and practices”.<sup>4</sup> Spiritual health has been identified as a fundamental dimension of people's overall health and well-being, permeating and integrating all the other dimensions of health (physical, mental, emotional, social and vocational). This is because spiritual health is a dynamic state of being, shown by the extent to which people live in harmony with themselves, others, someone/something above the human level, and their environment.<sup>5</sup>

‘Whole person medicine’ is a collective term used to describe all aspects of care required to restore and improve health in an individual. These include physical, psychological, social, cultural and spiritual elements.<sup>6</sup> Psychological and social aspects of illness are frequently addressed during routine clinical assessment, while spiritual aspects are often neglected. The therapeutic strategy linked to the spiritual

aspect of health has sometimes been called spiritual care. This is defined as an awareness of and sensitivity to the spiritual values of patients, and the provision and mobilization of spiritual resources appropriate to the patient in their situation<sup>7</sup>.

Globally, various public health bodies, including the World Health Organization, view spirituality as an important determinant of health status.<sup>2</sup> Patients consistently score spiritual matters as high on their list of concerns.<sup>8-12</sup> There is growing international recognition of the importance of whole-person medicine.<sup>13-16</sup> In the United Kingdom (UK), in the guidance produced by the General Medical Council's (GMC) document 'Tomorrow's Doctors', it is recommended that medical students should appreciate '*the importance of clinical, psychological, spiritual, religious, social and cultural factors*', and respect '*patients' right to hold religious or other beliefs*' and '*take these into account when relevant to treatment options*'.<sup>16</sup> However, although the GMC requires that UK medical schools address such issues in the undergraduate curriculum, the extent and content of such current teaching is not particularly clear.<sup>17-19</sup>

There are widespread differences in culture, religious practice and healthcare systems worldwide. The impact of medical specialty and working environment on the healthcare professional's own spirituality is equally unclear.<sup>20</sup> How such influences collectively shape both the practice, and the teaching of whole person medicine at an undergraduate level, is uncertain.<sup>21-22</sup> Surveys of practice at medical schools are dominated by data from USA.<sup>23-30</sup> Recent review articles have called for more studies from elsewhere in the world. Studies from other healthcare settings are few and do not directly compare practice in the UK and elsewhere.<sup>23</sup>

From the sparse data published, it seems currently that a minority of UK medical schools, including Queen's University Belfast (QUB), address the GMC guidance on spirituality in healthcare in the undergraduate medical curriculum and provide some training in spiritual issues. Content and approach varies considerably and a diverse range of teaching and assessment methods prevail.<sup>17-19</sup> Some schools do provide core teaching on the importance of faith in coping with illness for some patients, and information on how to liaise with chaplaincy services. However teaching is more frequently optional, delivered to small numbers within supplementary modules and courses, rather than the core undergraduate medical curriculum. Only four of the medical schools provided opportunities to accompany chaplains on patient visits. Few studies have reported the views of UK medical school Teaching Faculty and students. We recently reported that amongst our own medical students and Faculty at Queen's University Belfast there is general support for a spiritual aspect to healthcare and recognition of the importance this has for patients. Although there was support for the provision of spiritual care for appropriate patients, there was less consensus as to whether this should be delivered by doctors themselves or left to others.<sup>31</sup> There is agreement that spiritual issues impacting patient management should be included in the undergraduate curriculum, but less agreement on how or arrangements for assessment.<sup>31</sup>

## **AIMS AND OBJECTIVES**

Our purpose was to extend our recently published study<sup>31</sup> (conducted in Belfast, United Kingdom) by exploring the attitudes of a cohort of healthcare personnel working in a rural community hospital in Uganda about addressing spiritual issues in healthcare training and delivery. The outcomes included: attitudes towards and relative importance of the components of whole person medicine; what proportion of participants felt that spirituality is an important determinant of healthcare interactions and outcomes; defining the extent that such issues should be covered in the undergraduate curriculum. Since the Ugandan cohort included both Ugandan nationals and colleagues from Northern Europe currently on elective placement at the hospital, it was possible to consider the extent (if any) to which views were shared or differed across cultures. Inter-professional differences were also explored by comparing the viewpoints of medical doctors, clinical officers and medical students with those of nurses and student nurses.

## **METHODS**

### **Study design**

A self-administered questionnaire was designed to elicit views of medical students and of Faculty at Queen's University Belfast (QUB) Medical School<sup>31</sup> and extended to personnel based at a rural community hospital, Kagando, Uganda. A small number of questions relevant to local QUB/United Kingdom practice were removed but otherwise the questions were reproduced entirely. To enable standardization and facilitate data analysis, a five point Likert scale was chosen for each response. The first part of the questionnaire gathered demographic information. Subsequent study questions were grouped into three domains, structured as follows:

### **Domain 1: attitudes to whole person medicine**

Respondents graded their attitudes to the various components of whole person care (physical, psychological, social, spiritual) on a scale ranging from irrelevant to very important.

### **Domain 2: attitudes to spirituality and illness**

This domain addressed issues related to the interplay between spirituality and health, including the contribution of spiritual beliefs to health status. Respondents were asked to explore the relationship

between patient and physician spirituality and whether medical staff should share personal views on spirituality with patients.

### **Domain 3: attitudes to the training of healthcare staff in spiritual care**

This domain focused on medical education and examined views on the training and assessment of medical students in spiritual aspects of healthcare.

The questionnaire ended with a free text box to allow views expressed to be expanded or clarified, and to facilitate any other comments on the subject.

Ethical approval was granted by the QUB Medical School's Research Ethics Committee. In Uganda, ethical approval was obtained from the Medical Directorate of Kagando General Hospital. Paper versions of the questionnaire were provided by two of the authors (TA and CPA who at the time of the study were final year QUB Medical Students undertaking an eight week clinical elective at the hospital). Completed questionnaires were returned anonymously via a box placed in a central collection point in the hospital reception.

### **Data Analyses**

Quantitative (including comparison of proportions selecting the various options and relations between groups), and qualitative (assessing trends/themes) analysis was performed, as appropriate. Simple descriptive statistics were used to describe the distribution of responses for each question. Differences in responses between native Ugandans and visiting Europeans, and between doctors, clinical officers and medical students relative to nurses and nursing students were analysed by unpaired t-test.  $p < 0.05$  was regarded as significant. The free text comments were analysed by thematic analysis.

## **RESULTS**

### **Demographics of respondents**

Characteristics of the Ugandan cohort are presented in Table 1. Responses were obtained from 76 personnel working at Kagando General Hospital, Kasese District, in south-western Uganda. The 250 bed hospital includes paediatric, male and female medical and surgical wards and maternity, leprosy and tuberculosis units and out-patient clinics. Uganda was the country of birth for 72% of these respondents, with the remainder comprising overseas-trained healthcare staff and medical students on elective

placement, mostly from United Kingdom. Seventy-two (95%) believed in God /a Higher Power; 4 medical students from England and Sweden accounted for the non-believers (5%) in the cohort. Twelve (16%) respondents had received some prior training in provision of spiritual care; this included 5 medical professionals, 5 nursing professionals and 2 hospital chaplains, all of whom were native Ugandans. The training largely comprised guidance provided by their local churches in ministry and evangelism rather than specifically in a healthcare setting although 3 respondents had completed short approved courses in palliative care counselling. 2/3 of the respondents were male, but no marked differences were noted between male and female respondents in the responses discussed below.

<b>Characteristic</b>	<b>Response Percent</b>	<b>Response Count</b>
Medical doctor	13%	10
Nurse	13%	10
Medical student	32%	24
Nursing student	29%	22
Clinical officer	8%	6
Chaplain	2.5%	2
Other	2.5%	2
<b>Age</b>		
<=20 years	13%	10
20-30 years	74%	55
31-40 years	9%	7
> 40 years	4%	3
<b>Gender</b>		
Male	67%	51
Female	33%	25
<b>Country of birth</b>		
Uganda	73%	55
United Kingdom	21%	16
Other	6%	5

**Table 1** Characteristics of the Kagando cohort (N=76)

## Domain 1: Attitudes to whole person medicine

Attitudes of the entire Kagando cohort to the various components of whole person care are summarised in the first section of Table 2. There was overwhelming agreement that physical and psychological issues are very important. Although less strongly rated, the majority also felt that social and spiritual issues were very important. Sub-group analysis of the Kagando cohort indicated that spiritual issues were viewed as more important by native Ugandans than by visiting Europeans ( $p < 0.01$ , Table 3). Overall, respondents prioritised counselling, contact with a member of the patient's own faith community, and intercessory prayer as the three most important aspects in the provision of spiritual care for patients (Table 5). Subgroup analysis revealed that native Ugandans listed counselling and intercessory prayer as equally important followed by contact with a member of the patient's own faith community. In contrast, Europeans working in Kagando listed contact with a member of the patient's own faith community, followed by intercessory prayer and access to a chaplain in order of importance, with counselling afforded less priority than chaplaincy services. Nurses and nursing students were more likely to rate spiritual care as very important than doctors, clinical officers and medical students ( $p < 0.05$ , Table 4). Both professions listed counselling, intercessory prayer and contact with a member of the patient's own faith community as the most important aspects of spiritual care (Table 5).

<b>Attitudes to whole person medicine</b>	<b>Very important</b>	<b>Important</b>	<b>Neutral</b>	<b>Little importance</b>	<b>Irrelevant</b>
Physical treatment (drugs, surgery)	68 (89)	8 (11)			
Social care	46 (61)	28 (36)	2 (3)		
Psychological care	51 (67)	23 (30)	2 (3)		
Spiritual care	38 (50)	33 (43)	4 (5)		1 (1)
<b>Attitudes to influence of spirituality in illness</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly disagree</b>
Spiritual health contributes to physical health	31 (41)	39 (51)	3 (4)	3 (4)	
Religious faith or personal spirituality is an important aspect of lives of many patients	19 (25)	43 (57)	9 (12)	4 (5)	1 (1)



Patients generally want doctors to be aware of their religious / spiritual values and needs	12 (16)	24 (32)	25 (33)	13 (17)	2 (3)
Doctors should leave spiritual care to chaplains or others	4 (5)	8 (11)	13 (17)	41 (54)	10 (13)
An individual's faith and spiritual belief can affect their response to their clinical diagnosis and prognosis	28 (37)	40 (53)	4 (5)	4 (5)	
Sometimes patients recover for reasons which cannot be explained medically or scientifically	22 (29)	40 (53)	9 (12)	4 (5)	1 (1)
	<b>Never</b>	<b>Occasionally</b>	<b>Certain circumstances</b>	<b>Only if invited to</b>	<b>Always</b>
Health care workers should share their own spiritual beliefs with patients	6 (8)	12 (16)	34 (45)	18 (24)	6 (8)
<b>Attitudes to spiritual care in training of healthcare staff</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly disagree</b>
Instruction regarding world religions and faith practices should be part of medical/nursing undergraduate curriculum	14 (18)	39 (51)	18 (24)	4 (5)	1 (1)
Instruction in spiritual care is best delivered as an optional component for those who have a particular interest	7 (9)	33 (43)	13 (17)	19 (25)	4 (5)
Instruction in spiritual care should be incorporated into the core curriculum for all students	11 (14)	32 (42)	20 (26)	11 (14)	2 (3)

Instruction in spiritual care should be delivered by doctors and nurses	3 (4)	23 (30)	24 (32)	21 (28)	5 (7)
Training of healthcare workers should include shadowing hospital chaplains or others expert in spiritual care	20 (26)	37 (49)	11 (14)	7 (9)	1 (1)

**Table 2** Analysis of the responses for the entire group of Kagando respondents, presented as n (percentage).

<b>Attitudes to whole person medicine</b>	<b>Very important</b>	<b>Important</b>	<b>Neutral</b>	<b>Little importance</b>	<b>Irrelevant</b>	<b>p value for comparison</b>
Physical treatment (drugs, surgery)	48 (87), 20 (95)	7 (13), 1 (5)				0.3181
Social care	31 (56), 15 (71)	23 (42), 5 (24)	1 (2), 1(5)			0.3922
Psychological care	38 (69), 13 (62)	16 (29), 7 (33)	1 (2), 1 (5)			0.4635
Spiritual care	32 (58), 6 (29)	21 (38), 12 (57)	2 (4), 2 (9)	0 (0),0 (0)	0 (0), 1 (5)	0.0058**
<b>Attitudes to influence of spirituality in illness</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly disagree</b>	
Spiritual health contributes to physical health	29 (53), 2 (9)	24 (44), 15 (71)	1 (2), 2 (9)	1 (2), 2 (9)		0.0002***
Religious faith or personal spirituality is an important aspect of lives of many patients	16 (29), 3 (14)	36 (65), 7 (33)	3 (5), 6 (28)	0 (0), 4 (19)	0 (0), 1 (5)	0.0001***
Patients generally want doctors to be aware of their religious / spiritual values and needs	11 (20), 1 (5)	18 (33), 6 (29)	17 (31), 8 (38)	9 (16), 4 (20)	0 (0), 2 (9)	0.0328*

Doctors should leave spiritual care to chaplains or others	1 (2), 3 (14)	6 (11), 2 (9)	10 (18), 3 (14)	29 (53), 12 (57)	9 (16), 1 (5)	0.1068
An individual's faith and spiritual belief can affect their response to their clinical diagnosis and prognosis	16 (29), 12 (57)	31 (56), 9 (43)	4 (7), 0 (0)	4 (7), 0 (0)		0.0108*
Sometimes patients recover for reasons which cannot be explained medically or scientifically	14 (25), 8 (38)	29 (52), 11 (52)	7 (13), 2 (9)	4 (7), 0 (0)	1 (2), 0 (0)	0.1061
	<b>Never</b>	<b>Occasionally</b>	<b>Certain circumstances</b>	<b>Only if invited to</b>	<b>Always</b>	
Staff should share their own spiritual beliefs with patients	3 (14), 3 (5)	9 (16), 3 (14)	28 (51), 6 (28)	10 (18), 8 (38)	5 (10), 1 (5)	0.8695
<b>Attitudes to spiritual care in training of healthcare staff</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly disagree</b>	
Instruction regarding world religions and faith practices should be part of medical/nursing undergraduate curriculum	11(20), 3 (14)	25 (55), 14 (66)	16 (29), 2 (9)	3 (5),1 (5)	0 (0), 1 (5)	0.9655
Instruction in spiritual care is best delivered as an optional component for those who have a particular interest	7 (13), 0 (0)	28 (51), 5 (24)	7 (13), 6 (29)	10 (18), 9 (43)	3 (5), 1 (5)	0.0064**
Instruction in spiritual care should be incorporated into the core curriculum for all students	11 (20), 0 (0)	20 (36), 12 (57)	14 (25), 6 (29)	9 (16), 2 (9)	1 (2), 1 (5)	0.4800

Instruction in spiritual care should be delivered by doctors and nurses	3 (5), 0 (0)	18 (33), 5 (24)	12 (22), 12(57)	18 (33), 3 (14)	4 (7), 1(5)	0.8891
Training of healthcare workers should include shadowing hospital chaplains or others expert in spiritual care	19 (35), 1 (5)	25 (45), 12 (57)	7 (13), 4 (19)	4 (14), 3 (7)	0 (0), 1 (5)	0.0071**

**Table 3** Subgroup analysis from Kagando respondents: comparing responses of native Ugandans (55) with those of western European nationals (21) working on placement at the hospital. Number of responses from native Ugandans are shown first (with percentage), followed by those of Europeans (with percentage); for comparison between subgroups \*p<0.05; \*\*p<0.01; \*\*\*p<.005.

<b>Attitudes to whole person medicine</b>	<b>Very important</b>	<b>Important</b>	<b>Neutral</b>	<b>Little importance</b>	<b>Irrelevant</b>	<b>p value for comparison</b>
Physical treatment (drugs, surgery)	36 (90), 28 (88)	4 (10), 4 (12)				0.7417
Social care	26 (65), 15 (47)	13 (31), 15 (47)	1 (2), 2 (6)			0.11228
Psychological care	24 (60), 24 (75)	15 (38), 8 (25)	1 (2), 0 (0)			0.1476
Spiritual care	14 (35), 20 (63)	23 (58), 10 (31)	2 (5), 2 (6)	0 (0), 0 (0)	1 (2), 0 (0)	0.00476** *
<b>Attitudes to influence of spirituality in illness</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly disagree</b>	
Spiritual health contributes to physical health	10(25), 19(59)	25(63), 12(38)	2(5), 1(3)	3(8), 0(0)		0.0027***
Religious faith or personal spirituality is an important aspect of lives of many patients	8(20), 11(34)	20(50), 19(59)	7(18), 2(6)	4(10), 0(0)	1(2), 0(0)	0.0086**

Patients generally want doctors to be aware of their religious / spiritual values and needs	2 (5), 11 (28)	12 (30), 9 (28)	15 (38), 8 (25)	8 (20), 4 (12)	3 (8), 0 (0)	0.0008***
Doctors should leave spiritual care to chaplains or others	3 (8),0 (0)	5 (12), 2 (6)	7 (18), 6 (19)	23 (58), 17 (53)	2 (5), 7 (22)	0.0268*
An individual's faith and spiritual belief can affect their response to their clinical diagnosis and prognosis	17 (42), 10 (31)	22 (55), 16 (50)	1 (2), 3 (9)	0 (0), 3 (9)		0.0349*
Sometimes patients recover for reasons which cannot be explained medically or scientifically	15 (38), 5 (16)	20 (50), 19 (59)	5 (12), 3 (9)	0 (0), 4 (12)	0(0), 1(3)	0.0086**
	<b>Never</b>	<b>Occasionally</b>	<b>Certain circumstances</b>	<b>Only if invited to</b>	<b>Always</b>	
Staff should share their own spiritual beliefs with patients	4 (10), 2 (6)	7 (18), 4 (12)	14 (35), 20 (62)	14 (35), 3 (9)	1 (2), 3 (9)	0.9787
<b>Attitudes to spiritual care in training of healthcare staff</b>	<b>Strongly agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly disagree</b>	
Instruction regarding world religions and faith practices should be part of medical/nursing undergraduate curriculum	4 (10), 8 (25)	23 (58), 15 (47)	11 (28), 7 (18)	1 (2), 2 (6)	1 (2), 0 (0)	0.2928
Instruction in spiritual care is best delivered as an optional component for those who have a particular interest	1 (2), 5 (16)	13 (33), 18 (56)	9 (22), 4 (12)	15 (38), 4 (12)	2 (5), 1 (2)	0.0015*

Instruction in spiritual care should be incorporated into the core curriculum for all students	2 (5), 6 (19)	19 (48), 13 (41)	12 (30), 7 (22)	6 (15), 5 (12)	1 (2), 1 (2)	0.4226
Instruction in spiritual care should be delivered by doctors and nurses	2 (5), 0 (0)	10 (25), 12 (38)	18 (45), 6 (19)	8 (20), 12 (38)	2 (5), 2 (6)	0.4478
Training of healthcare workers should include shadowing hospital chaplains or others expert in spiritual care	6 (15), 12 (3)	23 (58), 12 (38)	6 (15), 5 (16)	4 (10), 3 (9)	1 (2), 0 (0)	0.1777

**Table 4** Subgroup analysis from Kagando respondents: comparing responses of doctors, clinical officers and medical students (40) with those of nurses and nursing students (32). Number of responses from medical group are shown first (with percentage), followed by those of nursing group (with percentage); for comparison between subgroups \*p<0.05; \*\*p<0.01; \*\*\*p<.005.

	Kagando respondents	Native Ugandans	Europeans	Doctors, Clinical Officers and medical students	Nurses and nursing students
<b>Number of respondents</b>	76	55	21	40	32
<b>Aspect of spiritual care</b>					
Counselling	49 ( <b>65</b> )	44 ( <b>80</b> )	5 (24)	19 ( <b>48</b> )	26 ( <b>81</b> )
Sacred music and songs	10 (13)	9 (16)	1 (5)	5 (12)	5 (16)
Religious rites and ceremonies	15 (20)	12 (22)	3 (14)	5 (12)	9 (28)
Healing services	20 (26)	19 ( <b>35</b> )	1 (5)	7 (18)	10 (31)
Access to a chaplain	17 (22)	6 (11)	11 ( <b>52</b> )	13 (33)	3 (9)
Sacred texts/readings	26 (34)	17 (31)	9 (43)	14 (35)	10 (31)
Intercessory prayer	47 ( <b>62</b> )	35 ( <b>64</b> )	12 ( <b>57</b> )	23 ( <b>58</b> )	20 ( <b>63</b> )

Contact with member of patient's own faith community	32 <b>(42)</b>	14(25)	18 <b>(86)</b>	21 <b>(53)</b>	10 (31)
None of these/other (please specify)	0	0 (0)	0	0 (0)	0 (0)

**Table 5** Respondents were asked to select a maximum of three aspects from those listed which they considered were most important in provision of spiritual care. The responses are presented as n (percentage of cohort selecting this aspect). Responses are shown for the entire cohort and for various subgroups.

### **Domain 2: Attitudes to spirituality in illness**

Most respondents agreed that spiritual health contributes to physical health and that patients can sometimes recover for reasons that cannot be explained medically or scientifically (Table 2). They considered religious faith/personal spirituality to be an important aspect of the lives of many patients, affecting response to their clinical diagnosis and prognosis. However, respondents were divided on whether patients wanted doctors to be aware of such religious values and spiritual needs. Most respondents adopted a neutral stance, and the majority were inclined to leave spiritual care to chaplains or others. Native Ugandans more frequently agreed than Europeans that spiritual health was a contributor towards physical health and well-being and that religious faith or personal spirituality was held as important by many patients ( $p < 0.005$ , Table 3). Native Ugandans were more inclined to the view that patients wished their doctors or other staff caring for them to be aware of their spiritual needs ( $p < 0.05$ ). Only 16% of respondents at Kagando felt that spiritual care should be left to chaplains or other specialists. However the majority of both native Ugandans and Europeans felt staff should only share their own religious beliefs and spiritual viewpoints under certain circumstances or when specifically invited to do so by patients. Nursing professionals were more strongly inclined than their medical colleagues that spiritual health contributes to physical health, is an important aspect of the lives of many patients and that patients generally want their doctors to be aware of this (Table 4). Medical professionals more strongly held the view that a patient's faith can affect their response to their diagnosis and prognosis and that patients sometimes recover for reasons which cannot be explained medically or scientifically; their nursing counterparts however more strongly disagreed that doctors should leave provision of spiritual care to chaplains or others.

### **Domain 3: Attitudes to inclusion of spiritual care training for health care staff**

Most respondents felt that instruction in world religions and faith practices and in delivery of spiritual care should be incorporated into the undergraduate medical/nursing curriculum; opinion was divided however

as to whether this should be delivered as a compulsory or optional component (Table 2). No difference was evident in this regard between native Ugandan and European respondents (Table 3). Neither sub-group had strong views on whether instruction in spiritual care should be provided by doctors and nurses themselves or left to others, but native Ugandans were more strongly in favour that training of healthcare workers should include shadowing hospital chaplains or other experts in provision of spiritual care (Table 3). Medical professionals were more divided in their viewpoint on whether training should be optional or compulsory; nurses were more inclined to favour an optional approach (Table 4).

## **THEMATIC ANALYSES OF FREE TEXT COMMENTS**

Twenty-four of 76 respondents (33%) added free text comments. Recurring viewpoints, themes and differences were identified, and are presented in categories.

The influence of spirituality as an inherent part of health was identified, particularly by native Ugandans:

*“Spirituality and faith brings hope and can contribute to the healing process, if it is lacking there can be stress-related illness.” (Ugandan male doctor)*

*“It is when people are unwell, sick that they are more spiritually conscious and would welcome every word that builds their spirit.” (Ugandan male medical student)*

*“Everything you do in Africa is connected with spirituality; in Africa almost everyone believes in spiritual power; Africa is a spiritual nation, patients want to be near the hills.”(Ugandan male hospital chaplain)*

The importance of spiritual care was recognised, particularly by nursing students:

*“Patients strongly need spiritual support by any staff- doctor, nurse- not only chaplain or priest.” (Ugandan male student nurse)*

*“Spiritual care is very important in care of all patients but cannot be effective without physical care.” (Ugandan male student nurse)*

*“Spiritual care should go hand in hand with medical and nursing care plans.” (Ugandan male student nurse)*

*“If health workers cannot offer their patients spiritual care then they should refer them to those who can help since they will often come across patients who may not get well with medicine given, those who need forgiveness and are depressed and unhappy.” (Ugandan male clinical officer)*



A note of caution and need for respect for differing viewpoints was indicated by some:

*“Spiritual care is needed by patients but cannot be imposed on those unwilling to take it up.” (Ugandan male doctor)*

*“I believe there are many patients who value spiritual care as well as there are many who do not; it is important for the healthcare system to provide for those patients who request religious support but this should never be forced on patients.” (Swedish female medical student)*

Many identified a need for more guidance and training in the area of spirituality and interaction with patients:

*“A component of healthcare training much missing.” (UK male medical student)*

*“Spiritual education should be given to everyone in the medical sector.” (Ugandan female student nurse)*

*“Spiritual care training should be undertaken by those who have an interest.” (Ugandan male medical student)*

But the challenges associated with delivering such training were recognised, particularly by Europeans working at Kagando:

*“In a spiritually diverse community, a curriculum to educate health workers on spiritual care of patients would have to be broad-based. This might prove a great challenge for both students and educators.” (Ugandan female doctor).*

*“In terms of training for awareness of patient’s concerns as opposed to addressing spirituality of doctors so as not to isolate those trainees who do not agree with the religious content.” (UK female medical student, humanist)*

*“Education should be provided by those who are experts on religion- doctors or nurses may not have enough knowledge, yet hospital chaplains may be focused only on their own religion and lack knowledge of other.” (Swedish female medical student)*

*“Experience with a chaplain would probably be as beneficial as many other key clinical experiences however to incorporate it onto the course might produce a negative response amongst medical students.” (UK male medical student)*

## DISCUSSION

### Views on a spiritual component to health and provision of spiritual care

Comparison of the views of the respondents based at Kagando with those of our previously published findings<sup>31</sup> relating to a cohort from Queen's University Belfast (QUB) Medical School in Northern Ireland, United Kingdom is informative because data on the generalizability of views across cultures and organisations are largely lacking. There was overwhelming agreement amongst both studies that physical, psychological and social issues are important aspects of patient care. However Kagando respondents more frequently agreed that spiritual health was a contributor towards physical health and well-being and consequently rated spiritual care more strongly than their QUB counterparts. These findings are perhaps not surprising given that 95% of the Kagando cohort (and 100% of native Ugandans) expressed belief in a higher authority/God compared to 55% of Faculty and 67% of students in the QUB cohort. It should be noted that the proportion of the general population of Northern Ireland (>83%) who believe in a higher authority/God is higher than in other regions of United Kingdom<sup>32</sup>, and also higher than average within the European Union<sup>33,34</sup> but still considerably lower than for the Kagando cohort (>95%). However fewer Faculty, and to an extent fewer medical students, in Belfast expressed belief compared to the general population. Similar trends have been identified in studies examining the views of medical students and Faculty relative to those of patients in USA.<sup>10, 12-14, 35</sup>

There was broad agreement between the QUB and Kagando cohorts that religious faith or personal spirituality was held as important by many patients and that patients can sometimes recover for reasons that cannot be explained medically or scientifically. Both the Kagando and QUB cohorts however were mainly neutral as to whether patients wished their doctors or other staff to be aware of these spiritual needs. The majority of QUB respondents clearly felt that healthcare staff should not share their own faith with patients, while the opposite view was prevalent in the Kagando respondents (79% of QUB respondents felt that staff should never or only occasionally share their faith/beliefs with patients, compared with 24% of Kagando respondents ( $p < 0.001$ )).

The majority of QUB respondents felt that doctors should be aware of spiritual interventions which may benefit patients but there was a majority view that doctors themselves should in general not be providing this spiritual care for their patients. In contrast with QUB respondents, the Kagando respondents were more willing to get involved in spiritual care. Only 16% of respondents at Kagando felt that spiritual care should be left to chaplains or other specialists and not clinical staff in contrast to 45% of QUB respondents.

Overall, the Kagando cohort gave more weight to availability of prayer than their QUB counterparts and this was particularly evident in the responses of the native Ugandans, but both cohorts broadly supported access to counsellors, and visits from chaplains and/or members of the patient's own faith community.

While intercessory prayer is undertaken discreetly by visiting chaplains on the wards of NHS hospitals within UK, there is probably broader cultural acceptance and open practice in the Ugandan setting.

### **Views in regard to training**

In contrast with QUB respondents, the Kagando cohort felt more strongly that spiritual issues should be incorporated within healthcare training (some advocating that it be compulsory) and were more willing to participate in delivering such training to other healthcare staff. In regard to the content of such training, while generally supported in both studies, more Kagando respondents felt that basic knowledge of world faiths and related practices should be incorporated into the core undergraduate medical/nursing curriculum (70% versus 47% QUB cohort). A majority of Kagando respondents also agreed that spiritual care should be part of the core undergraduate curriculum, in contrast to QUB respondents (57% versus 37%). Free text comments indicated that while the QUB respondents felt that basic awareness of, and respect for, patient beliefs that could impact care should be taught in the core curriculum, they were more reticent about inclusion of instruction in provision of spiritual care. Many QUB respondents have identified a need for guidance in the difficult area of spirituality and interaction with patients as they have been uncertain how to respond when patients have broached such matters in conversation. UK General Medical Council guidance on sharing faith in the clinical setting<sup>36</sup> and recent high profile reports in the national press<sup>37,38</sup> may have contributed to many healthcare workers becoming more cautious about doing so; this is also reflected in some of the free text comments from Europeans in Kagando.

A greater proportion of the Kagando respondents felt students would benefit from time spent with chaplains or others with specialist expertise in delivery of spiritual care (75% v 47% QUB cohort). This perhaps reflects the higher profile and hence greater exposure to and more general awareness and acceptance of the work of hospital chaplains in the African context. Those medical students who have been afforded opportunities to shadow a hospital chaplain in Belfast invariably find this an insightful and invaluable experience even when they themselves do not profess strongly held, or indeed any, religious belief<sup>19</sup>. Having shadowed a chaplain on ward rounds, they develop a greater awareness of the benefits of spiritual care for all patients, even for those patients who do not have strong religious faith or indeed, any. They recognise that much of the interaction between chaplain and patient is not overtly religious in content.

### **Sub-group analysis of the Kagando study**

The Kagando cohort comprised a significant minority of non-Ugandan respondents, including qualified healthcare personnel and medical students on clinical elective, all of whom came from Northern Europe. The differences in opinions expressed by native Ugandans alone in the Kagando study and those of the respondents in the Belfast study<sup>31</sup> were more apparent and this might suggest the existence of divergent cultural influences between the sub-Saharan African and Northern European populations. It might be

anticipated that the views of Europeans working in Kagando might diverge from those of native Ugandans given differences in prior experiences and cultural influences. Alternatively, it is conceivable that the motivation of the European respondents to work in a poorer-resourced healthcare setting in the majority world could also represent a practical outworking for many of them of their own personal beliefs. This might cause their viewpoints to diverge from those of European healthcare workers generally.

Although the majority of respondents in both cohorts were students, the Kagando cohort included nurses and nursing students while the QUB cohort did not. Nursing professionals were inclined to attribute greater importance to spiritual health and support the involvement of doctors in delivery of spiritual care. Medical professionals held more strongly to the view that a patient's faith can affect their response to their diagnosis and prognosis and that patients sometimes recover for reasons which cannot be explained medically or scientifically. Despite this, they were reluctant to become more directly involved in delivery of such care themselves with a preference to utilise the expertise of other members of the multi-disciplinary team, including chaplains. Although of comparable age, most of the Kagando cohort was male in contrast to the QUB cohort the majority of whom was female. However an influence of gender was not apparent in the viewpoints expressed by the Kagando respondents, and cannot account for different inter-professional viewpoints since the majority (72%) of nursing professionals working at Kagando were male.

Notwithstanding such limitations, important differences were evident in the responses of the native Ugandan and European respondents. Possibly limitations may under-represent the actual differences in attitudes prevalent in the developed and majority worlds. However, this was a small pilot study, facilitated by two of our final year medical students during their clinical elective undertaken at a rural community hospital in Uganda. Their visit afforded a timely opportunity for comparison with the views of undergraduate students from a regional medical school in United Kingdom which we recently reported.<sup>31</sup> Generalisation of the findings based on such a small sample size from one geographical location and healthcare setting should be avoided. The findings may not be representative of the vast regions of two different continents with diverse socio-cultural and religious components. Nonetheless this pilot study provides the rationale to undertake a much more ambitious multi-centre study comparing attitudes prevalent in various healthcare settings and training facilities drawn from geographically and culturally diverse regions of the two continents.

## **CONCLUSION**

Overall there is agreement about some aspects of spirituality in healthcare. However staff and students in the African setting would seem more favourably disposed towards providing spiritual care routinely for patients, and towards delivery of training for healthcare staff in spiritual care provision. Thus, differences in background, culture and healthcare organisation are important, and indicate that the wide range of views expressed in the current literature, the majority of which has originated in North America, are not necessarily

transferable between locations. Assessment of these issues locally may be the best way to plan such training and incorporation of spiritual care into clinical practice. ■

## **AUTHORS' CONTRIBUTIONS**

MH undertook this comparison as a sub-study of his main project as a postgraduate student in fulfillment of the requirements of the research dissertation module of the Masters in Medical Education course at QUB. DB proposed and supervised this studentship and assisted with study design and data analysis and interpretation. TA and CPA were at the time of this study, 5<sup>th</sup> year medical students at QUB undertaking their final year overseas clinical elective; they coordinated distribution of the questionnaire and collection of the data in Kagando, Uganda.

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