

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304  
(A-24)

Introduced by: Academic Physicians Section

Subject: Spirituality in Medical Education and Practice

Referred to: Reference Committee C

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1 Whereas, current AMA policy recognizes the importance of spirituality concerns to many  
2 patients and encourages patient access to spiritual care services (H-160.900) but does not  
3 detail how the provision of spiritual care to patients would optimally involve physicians,  
4 physicians-in-training, or other members of the care team; and

5  
6 Whereas, the term “spiritual care” does not require, yet does not exclude, the invoking of any  
7 general or specific religious beliefs; rather, spirituality is broadly defined as seeking meaning,  
8 purpose, and connectedness, and is inclusive of all ways people may understand spirituality in  
9 their lives; and

10  
11 Whereas, our AMA’s policies on diversity, equity, and inclusion note the need to respect people  
12 and their diverse backgrounds, which applies specifically to the quality and equity of patient  
13 care, in that members of medical care teams should demonstrate respect for the culture and  
14 spirituality of the patient (and the patient’s family); and

15  
16 Whereas, many health organizations, including the World Health Organization (WHO), via its  
17 Resolution on Palliative Care, have noted the need for prevention and relief of suffering by  
18 means of early identification and correct assessment and treatment of pain and other problems,  
19 whether physical, psychosocial, or spiritual – and in the case of WHO, have declared that the  
20 treatment of all severe pain, including spiritual pain, is a human right;<sup>1</sup> and

21  
22 Whereas, many patients value clinicians who are able to integrate inquiry about patients’  
23 spirituality as related to their health, and benefit from access to specialist spiritual care services,  
24 when such access is enabled for them; and

25  
26 Whereas, a Delphi review of the literature found sufficient evidence to recommend education on  
27 spirituality and health in the care of patients with serious and/or chronic illness;<sup>2,3</sup> and

28  
29 Whereas, patient referral and access to spiritual care services would be enhanced if all  
30 physicians and medical students had learned how to provide generalist spiritual care through  
31 the assessment and treatment of spiritual distress as a clinical symptom, with treatment options  
32 to include compassionate listening and presence to patients’ suffering, reflective inquiry to  
33 enable patients to fully express their spiritual distress, referral to and collaboration with spiritual  
34 care specialists, and continued follow up with the patient on spiritual issues as indicated; and

35  
36 Whereas, instruction in medical education regarding spiritual health as part of whole person  
37 care, assessment, and treatment of spiritual distress could be expected to enhance “emotional  
38 intelligence” and the recognition of opportunities for either providing spiritual care or referring  
39 the patient to a spiritual care specialist; and

1 Whereas, burnout—a condition characterized by feelings of pervasive energy depletion or  
2 exhaustion, negativism or cynicism about one’s occupation or occupational role, and/or a sense  
3 of inadequacy or ineffectiveness in one’s occupational role, is a pervasive emotion and state  
4 among clinicians and clinicians-in-training; and  
5

6 Whereas, spiritual distress can contribute to burnout across the continuum of medical education  
7 and practice, with an association between increased burnout and decreased meaning in work,  
8 while the practice of spirituality may be a protective factor against burnout, with such  
9 interventions as “reflection rounds” helping health professionals and students rekindle their  
10 sense of meaning in their chosen vocation;<sup>4</sup> and  
11

12 Whereas, it is therefore reasonable to hope that by providing physicians and physicians-in-  
13 training with opportunities to become more well-educated regarding matters of spirituality, and  
14 by enabling them to implement a spiritual approach to their own life and life stresses—including  
15 use of spiritual resources such as meditation, seeking professional spiritual care if needed,  
16 and/or finding a spiritual community of support—that these individuals may be favorably  
17 impacted and be less susceptible to burnout; and  
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19 Whereas, by extension, increased knowledge and awareness of spiritual principles may  
20 enhance the abilities of caregivers to not only provide more effective care to others, but also to  
21 provide more effective self-care to themselves; therefore be it  
22

23 RESOLVED, that our American Medical Association amend Policy H-160.900 to read as  
24 follows:  
25

26 Addressing Patient Spirituality in Medicine Medical Education and Practice  
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- 28 (1) Our AMA recognizes the importance of individual patient spirituality and its impact on  
29 health and encourages patient access to spiritual care services.  
30
- 31 (2) Our AMA encourages the availability of education about spiritual health, defined as  
32 meaning, purpose, and connectedness, in curricula in medical school, graduate medical  
33 education, and continuing physician professional development as an integral part of  
34 whole person care, which could include:  
35 (a) assessing spiritual health as part of the history and physical;  
36 (b) addressing treatment of spiritual distress by the clinician, with appropriate referral to  
37 spiritual care professionals;  
38 (c) acknowledging patients’ spiritual resources;  
39 (d) developing compassionate listening skills;  
40 (e) ensuring ongoing follow-up of patients’ spiritual health by clinicians as appropriate;  
41 (f) describing respect for the spiritual, religious, existential, and cultural value of those  
42 they serve and understanding why it is important to not impose their own personal  
43 values and beliefs on those served; and  
44 (g) self-reflection on one’s own spirituality within professional development courses,  
45 especially as related to their vocation and wellbeing. (Modify Current HOD Policy)  
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Fiscal Note: Minimal - less than \$1,000

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## REFERENCES

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 homebased 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.

## 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.

### Redesigning the Medicare Hospice Benefit D-330.895

Our American Medical Association advocates for:

1. A 21st century evolution of the Medicare hospice benefit that meets the quadruple aim of health care; advances health equity; and improves access, support, and outcomes for seriously ill patients across all geographies, including underserved and low-resource communities; and
2. A reformed Medicare hospice benefit that may incorporate the following components:
  - a. Hospice eligibility should not be based solely on a specified prognosis or life expectancy but rather on patients' needs.
  - b. Patients must continue to have an open choice of hospice providers.
  - c. Hospice services, including telehealth or telemedicine, should be provided by a full, physician-led interdisciplinary team.
  - d. Patients and their caregivers should receive adequate support using home- or facility-based hospice services, identified by a thorough assessment of their social determinants of health. This would incorporate 24-hour a day care for beneficiaries with very limited life expectancy who lack around the clock caregivers.
  - e. Patients should have concurrent access to disease-directed treatments along with palliative services.
  - f. Payments to hospices should be sufficient to support the quality, experience, scope, and frequency of care that beneficiaries deserve throughout the later stages of serious illness as dictated by their physical, psychological, social, spiritual, and practical needs.
  - g. The hospice benefit should be consistent, including with regard to the quality and intensity of services, regardless of which Medicare program or entity pays for services.
  - h. Metrics for health provider accountability should focus on those aspects of care and experience that matter most to patients, families, and caregivers.