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Currents in Pharmacy Teaching and Learning 3 (2011) 260–266

*Currents
in Pharmacy
Teaching
& Learning*

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Review

Integrating spirituality in patient care: preparing students for the challenges ahead

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Abstract

Over the past several decades, there has been an increased interest in the relationship among religion, spirituality, and health care. In view of this renewed awareness, about 79% of US medical schools now offer some variation of spirituality in their curriculum; 75% of these require medical students take at least one course in spirituality. In contrast to this, the most recent data indicate that only 21% of the Colleges of Pharmacy in the US offer any form of spirituality training in their curriculum. To promote spirituality in pharmacy care and better equip future pharmacists to more readily address the spiritual dimension of care in their practices, an elective course was developed and implemented. The course focused on the conceptual foundations of the role of spirituality in patients' health, the primary literature supporting this relationship, and the development and performance of methods in which to appropriately incorporate spiritual assessment and care into pharmacy practice. A detailed description of the design created, the learning objectives posited, the classroom techniques and activities employed, and the assessments used are described in this article.

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Keywords: Spirituality; Patient care; Pharmacy education

Religion, spirituality, and medicine have a long history in common. Religion and spirituality have been essential components in health care and the practice of medicine since ancient times.¹ Earliest records indicate that medicine originally developed in religious contexts and that medicine and religion have worked in a collaborative relationship to promote healing for thousands of years.² Religious leaders and clerics served as both physical and spiritual healers and religious institutions became the first health care institutions.³ A schism between religion and medicine became apparent by the mid-17th century as the authority of the church was continually challenged by medical advances.

Scientific advances in the mid-19th century brought about a deeper division between religion and the practice of medicine. The division continued to widen with the rapid advances of medical science in the 20th century. During the mid-1900s, medicine shifted from a more holistic care to a disease-centered model that focused more on science and technology.

Over the past several decades, however, there has been an increased interest in the relationship among religion, spirituality, and medicine. The advent of end-of-life care and the resurgence of complementary and alternative medicine have served as catalysts in heightening the awareness of the role that religion and spirituality play not only in how health and illness are perceived, but also in how patients and health care professionals interact with one another.³ Both movements, with their focus on care of body, mind, and spirit, promoted a renewed interest in the other human dimensions of care, including the spiritual dimension.

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Other growing areas of interest in spirituality in health care include published research and medical education. Before 1987, a review of published medical literature over the past century reported that there were more than 200 studies that contained religious terminology.⁴ In the 1990s it is reported that more than 1500 research studies, research reviews, articles, and clinical trials were published on the connection of spirituality or religion to medicine and health, indicating a burgeoning interest in the relationship among religion, spirituality, and medical practice.⁵ There was also an accompanying shift in medical education during this time with an increasing focus on the influence of spirituality in health care. A growing number of medical and nursing schools, medical residency programs, and academic medical schools began to incorporate the spiritual dimension of care into their curriculum.⁶ In 1999, the Association of American Medical Colleges (AAMC) acknowledged the importance of spirituality in medical practice in a 1999 Medical School Objectives Project, recognizing that spirituality is not only a factor that contributes to health in many persons but also influences how patients and health care professionals perceive health and illness and how they interact with one another.⁷

As early as 1989, spirituality was recognized as an important element in pharmacy education. In an opinion statement, Welty noted that pharmacy educators and leaders must carefully consider spiritual issues when planning for the preparation of future pharmacy professionals. He states, “We cannot continue to educate students in a spiritual vacuum if we are going to prepare effective pharmacists for the future.”⁸ Yet statistics indicate that pharmacy education lags behind in its interest and effort to incorporate spirituality into pharmacy curricula. A 2003 research study entitled “The spiritual aspect of patient care in the curricula of colleges of pharmacy” reported that only 21% of the colleges of pharmacy in the US and Canada provide training in how to address faith and spiritual issues.⁹ The researchers concluded that incorporating patients’ spiritual needs into the decision-making process will contribute to improvement in the health outcomes of their patients: “As pharmacy seeks to define and develop a greater professional focus on patient care, we must work to develop an outward-oriented worldview that encompasses the entire patient, including the SAPC [spiritual aspect of patient care].”⁹

Some pharmacy programs have begun to create courses to fill this need. The abstract by Cryder briefly describes a 10-week elective course with 49 students.¹⁰ Based on the pre/post-questionnaire administered to students in the class, as well as 12 students in a control group, he reports that students in the class had greater competency at both identifying and discussing spiritual issues with patients, as well as had an increased likelihood of performing a spiritual assessment on a patient (similar to Jafari), yet he provides no information on the content or design of the course.

In a letter to the editor, Campbell provides information about a course administered at the University of Oklahoma

College of Medicine.¹¹ This was a two-hour elective course that met daily over one week and provided approximately 36 hours of cumulative contact time. It was interdisciplinary in nature and included both medical and pharmacy students. Course content included discussions related to dealing with the first patient death, “Do Not Resuscitate” orders, taking a spiritual belief assessment, integrating spiritual beliefs into practice, and requiring students to explore their own faith traditions. To support the effectiveness of the course, the authors present pre/post-survey data that indicate students enrolled in the course were more likely to ask about a patient’s spirituality, although some students wanted a cue from patients before engaging in this type of discussion. In addition, some barriers identified were that some students still felt unprepared to engage patients, were concerned about patient anger, were fearful, or were generally still too uncomfortable with their own spiritual beliefs to engage patients at this time.

On the whole, however, the published literature provides little information on course design, delivery, or content for courses intended to educate students about this topic that is integral to patient care. This article presents one such course and provides information on the learning objectives, design, learning activities, and evaluation processes used.

Course description and design

Spirituality in Healthcare was a two-credit-hour elective course held once a week and offered in the fall semester to third-year pharmacy students seeking to fulfill their elective credit hour requirement. The purpose of the course was to address the correlation between spirituality and its effect on health care through development of baseline knowledge of the subject, increasing familiarity of the published literature available in this area, as well as guide students in the appropriate application. Table 1 lists the course goals with their corresponding learning outcomes. To achieve these goals and outcomes, the course was divided into three general sections: introduction to the principles of theosomatic medicine,¹² evaluation of spirituality in the literature, and application role plays.

This course was offered at a private, nondenominational Christian University with an ethnically and culturally diverse student population. The School of Pharmacy had an approximate enrollment of 300 students. Course enrollment was limited to 25 pharmacy students per offering to promote an environment of openness, intimacy, and/or connectedness. Students enrolled had already completed most of their Therapeutics coursework. This contributed to their ability to correlate the advantages of addressing the spiritual component of disease prevention and treatment. This placement also meant students had completed their training in patient communication that facilitated their ability to complete required activities, as well as practice interviewing patients. The only prerequisite was the successful completion of

Table 1
Course goals, objectives, activities, and assessments

Goal	Objective	Activity	Assessment
Provide students with an appreciation of the body of literature addressing effects of spirituality and religiosity on health care outcomes	<ol style="list-style-type: none"> 1. Describe the historical context of spirituality in health care 2. Define the 7 principles of theosomatic medicine and relate them to primary literature 	<ol style="list-style-type: none"> 1. Didactic lecture 2. Didactic lecture followed by a facilitated discussion of the concepts presented with emphasis on the interaction of these concepts in the students' own lives 	<ol style="list-style-type: none"> 1. Formative quizzes on 7 principles 2. Participation in discussion
Provide students with the knowledge to assess the scientific merit of studies concerning the relationship between spirituality and religiosity in health care	<ol style="list-style-type: none"> 1. Define the 7 principles of theosomatic medicine and relate them to primary literature 2. Identify key studies in the field of spirituality in health care 3. Describe measures of spirituality in conducting clinical trials 4. Critically evaluate studies examining the health effects of spirituality 	<ol style="list-style-type: none"> 1. Didactic lecture followed by a facilitated discussion of the concepts presented with emphasis on the interaction of these concepts in the students' own lives 2. Student-led literature evaluation presented to the class 	<ol style="list-style-type: none"> 1. Final essay examination 2. Literature evaluations <ol style="list-style-type: none"> a. Instructor evaluation of presented literature evaluation b. Instructor assessment of critiqued literature evaluation 3. Participation score for engaging in discussion during literature evaluations
Gain an understanding of ways to apply spirituality and religiosity within the context of clinical practice	<ol style="list-style-type: none"> 1. Use methods of assessing spirituality in patient encounters 2. Accurately assess when and how to incorporate spirituality into patient encounters 	<ol style="list-style-type: none"> 1. Facilitated reading assignment in the Koenig textbook 2. Facilitated self-directed development of a spiritual history 3. Interviewing to obtain a spiritual history 4. Didactic presentation with facilitated discussion on assessing spiritual distress 5. Role-play scenarios followed by facilitated discussion 6. Guided reflective exercises after each role-play 	<ol style="list-style-type: none"> 1. Reading quiz 2. Participation score upon turning in spiritual history 3. Participation score for contribution to discussions 4. Role-play evaluation 5. Role-play reflection questions

required coursework in drug information so students were familiar with how to complete literature evaluations.

Three instructional methods were used in this course: (1) didactic lecture with facilitated discussion, (2) guided self-directed learning, and (3) active learning and collaborative learning. During the first seven weeks of the course, didactic lecture was the primary method of instruction as the students were introduced to the core concepts, principles, and relevant literature. Each of the seven lectures were followed by a facilitated discussion that reviewed the concepts presented in the lecture, but required students to attempt to apply them to their personal lives and experiences. The remaining eight weeks of the course used guided self-directed learning, active learning, and collaborative learning techniques. This part of the course was marked by a quiz on the assigned readings followed by a series of literature evaluation presentations and role plays both of which the students worked on in groups. Each of these three instructional methods is described below.

Didactic lecture with facilitated discussion

During the initial class meeting, the historical context of the role of spirituality in health care was presented, as well as the foundation for the course via introduction to the syllabus, the principles of theosomatic medicine, and assigned readings for each meeting. During the next six class sessions, each of the seven principles was presented in addition to a brief overview of supporting literature. Typically, the first few minutes of each class period was reserved to discuss any administrative issues along with setting the tone for the session. This was followed by a review of concepts previously discussed and then an introduction to the lecture principle of the day. After about 30 minutes of didactic lecture, students were given a 10-minute break. Upon their return, students would sit within predetermined randomized groups where a Think-Pair-Share method of instruction was used to aid in student engagement.¹³ During this time, students were asked to consider several questions

related to the topic presented. Each student would first self-reflect for five minutes about the questions and then discuss them within their group for 10 minutes. This intra-group discussion was followed by an instructor-facilitated class discussion of the questions, in which students were encouraged to speak about their experiences as they related to the theosomatic principle that had been presented that day.

Guided self-directed learning

At the first class meeting, students were assigned to read approximately 90 pages from *Spirituality in Patient Care: Why, How, When, and What* by Harold Koenig.¹⁴ Students were also informed at this time to expect a quiz on this material in week eight of the course. Because the reading was not directly discussed in class, the instructor prepared a list of learning objectives for each assigned chapter to focus students in their reading efforts. The purpose of the reading and quiz was to begin preparing students for the application portion of the course by providing baseline knowledge of the methods as well as “do’s and don’ts” associated with incorporating the spiritual aspect of patient care into their practice. Quiz questions were intentionally designed to be on the lower level of Bloom’s taxonomy (i.e., Knowledge and Comprehension). Thirty minutes were given at the beginning of class to complete the 34-question quiz. After the quiz, students were provided several examples of models used to take a spiritual history, such as SPIRIT (Spiritual belief system, Personal spirituality, Integration with spiritual community, Ritualized practices and restrictions, Implication for medical care, Terminal events planning), FICA (Faith, Importance and influence, Community, Address or application), HOPE (Sources of Hope, Organized religion, Personal spirituality and practices, Effects on medical care and end-of-life issues), and FAITH (Faith/spiritual beliefs, Application, Influence/importance, Talk/terminal events, Help).^{15–18} Each student was then required to complete two spiritual history interviews with two people of their choice—one person in the class and one outside the class.

Active learning and collaborative learning

Eight groups of three students were formed to complete both the literature evaluation project, as well as the role-play assignment. The literature evaluation exercise was designed to take place over a four-week period. The instructor selected eight primary literature articles referenced from the required or suggested reading texts that focused on the effect of spirituality on patient care outcomes. Appendix 1 contains references for articles students evaluated. One ar-

ticle was then assigned to each group. For each of these class meetings, student groups were assigned a task to perform: to present, to critique, or to question. Of the six groups participating during each class: two groups would present their assigned literature article using PowerPoint presentations, two groups would then critique the articles being presented using a group-created key, and two groups would participate in the discussion by questioning the group’s presenting. For preparation, the group presenting was responsible for uploading their presentation to eCollege, a course management system, at least 48 hours in advance of the presentation so the entire class would be able to review it. The group critiquing was responsible for preparing a journal club handout of the article being presented, which was used to evaluate the accuracy of the presenting group as well as assist in asking probing questions. Finally, the students in the questioning group were required to ask two general questions to the group presenting to receive credit.

After four weeks of the literature evaluations, role-play exercises began. This activity used the same groups of three students as the literature evaluation project. Eight scenarios based on various pharmacy practice settings were created, such as an independent pharmacy, a hospital, an ambulatory-care clinic, and hospice. Role-play packets included a coversheet that described the scenario setting and characters. In addition, the packet contained two different detailed character descriptions: one described internal thoughts, feelings, and motivators, and the other described physical appearance and bearing. One character per scenario was a pharmacist, a patient, and a family member, friend, or caregiver. Students were told not to disclose any information with regard to the internal thoughts, feelings, and motivators until the activity. All other information, however, could be discussed with other team members, although not with the class at large. At the start of each role-play, the background and characters were introduced to the class as a whole.

No scripts were provided or time limits set, thus students improvised in real time. Each interaction lasted approximately 5 to 10 minutes. Students carried out the role-play until the issue at large was either solved or the group believed it was solved. At the conclusion of the activity, students in the role-play were required to reveal any information that was not exposed. A class discussion followed to better identify the issue portrayed, highlight character revelations, and critique the group’s solution. Finally, the discussion focused on whether the pharmacist’s actions were appropriate because some scenarios were designed for the pharmacist to intervene and others designed to be inappropriate for a direct intervention. In addition, during this portion of the class, a clinical chaplain presented on identifying signs of patient spiritual distress and how pharmacists could assist. For each role-play activity, teams were required to submit a reflective summary related to the discussion.

Table 2
Course grade percentages

Course area of assessment	Activity with percentages	Percent of total grade
Professionalism and participation	Discussion, 10% Assignments, 5% Peer/self-evaluation, 5% Reading quiz, 10%	30%
Literature evaluation and critique	Presentation, 20% Critique, 15%	35%
Role-play scenario	Presentation, 15% Learning points summary, 10%	25%
Final examination	Take-home essay examination, 10%	10%

Student evaluation and assessment

Four primary aspects of student performance were assessed: professionalism and participation, literature evaluation performance, role-play performance, and a cumulative essay final examination. Table 2 lists the percentage breakdown of the total course grade. Course assessment in these areas was both formative and summative in nature depending on the type of activity and the outcome desired in the course. Each of these four components is addressed below.

Professionalism and participation

Various components, such as peer/self-evaluations from group projects, performance on a reading quiz, participation in discussions, and completion of assignments comprised the professionalism and participation grade. Because of the amount of group interaction required for the literature evaluation and role-play activities, students were required to complete a peer/self-evaluation form at the end of each of these projects. These forms required students to assess their teammates as well as their own performance based on six criteria from the tenets of professionalism using a 1 to 10 point scale, where a score of 1 indicated a poor performance and a score of 10 indicated an outstanding performance. The criteria included: honesty/integrity, respect for others, self-accountability, excellence of work, contribution to the group, communication, confidence, and the ability to accept and provide constructive criticism. Students were required to supply supporting evidence for their score. Another component assessed was the reading quiz, based on the Koenig required text. It was composed of multiple-choice questions worth 100 points. Participation in discussion was evaluated in four ways: (1) A three-question formative pop quiz on the theosomatic principles, (2) documented participation during facilitated and role-play discussions, (3) involvement during literature evaluations in the question-and-answer period if assigned to the questioning group, and (4) completion and submission of the spiritual history interviews. Full

credit was awarded if a student participated at least twice during the facilitated discussions and asked two questions while participating on the question team during the literature evaluations.

Literature evaluation performance

Literature evaluation grades were summative assessments comprising two components: the instructor's evaluation of the team during the presentation and the critique submitted by the team on a subsequent literature evaluation. Components of the evaluation included: background information, methodology, results, evaluation and critique of the study, presentation, the ability to answer questions, and the quality of the PowerPoint presentation. Because students were concurrently enrolled in a required drug literature evaluation course, statistical analysis was considered a bonus. Students who critiqued the presenting group used a descriptive ordinal grading scale to evaluate. Areas of critique included: background information, methodology, statistical analysis (if covered), results, and analysis of the study presented.

Role-play performance

Role-play interactions were assessed in two ways: team performance during the role-play and submission of reflective questions. Four criteria were used to assess performance: cohesiveness of character portrayal, active engagement, originality and innovation, and contribution to the character reveal. Of these areas, originality and innovation was the only group score. In addition, contribution to the character reveal, in which any additional information or patient agendas were discussed, was given double weight because it was expected that students would disclose their understanding of the patient's underlying motivations. Students were evaluated using a 1 to 10 point scale, where a score of 1 indicated a poor performance and a score of 10 indicated an outstanding performance. The second assessment was a group activity that required them to complete guided reflection questions. Reflection questions included items such as identifying deep-seated issues of the characters, giving a critical evaluation of the way in which the issues were handled, and discussing how they would deal with the situation if they were a pharmacist in the role-play.

Cumulative essay final examination

A three-question take-home essay examination was assigned as the final summative evaluation. Students were given one week to complete the examination. Each question presented a mini-case scenario that included a spiritual history of the patient and required four major questions be answered. A prewritten key was used for evaluation.

Table 3
Student course evaluations and comments

Criteria	2006	2007
Objectives and expectations met	4.4	4.3
Explained material well	4.4	4.6
Level of material appropriate	4.1	4.1
Well-prepared and organized	4.4	4.3
Starts on time	4.7	4.6
Ends on time	4.7	4.6
Materials assisted in learning	4.6	3.9
Class activities assisted in learning	4.4	4
Instructor had interest and enthusiasm	4.7	4.7
Free to ask questions, offer opinions, and disagree	4.7	4.6
Christian principles integrated	4.8	4.7
Gain of skill and knowledge in area taught	4.3	4.2
Instructor had genuine interest in students	4.7	4.7
Grade evaluations consistent with syllabus	4.3	4.5
Work returned in a timely manner	4.4	4.3
Work evaluated with helpful feedback	4.4	4.3
Consistent application of syllabus policies	4.4	4.5
Recommend instructor to others	4.3	4.2
Recommend course to others	4.2	4.1
Prepared academically for course	4.3	4.4
Instructor standards were high	4.2	4.4
Desire to continue learning in this area and will help me as a pharmacist	4.3	4.2

Values based on a 1 to 5 point Likert scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, Five = Strongly Agree.

Discussion

Student response to the course

Of the 24 students enrolled in the course, 18 students (75%) elected to complete course evaluations. For standard evaluations, the University uses a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Table 3 summarizes student responses to evaluation questions. The cumulative average for the course was a 4.37, which indicated that most students agreed to “strongly agreed” with most statements in the evaluation. In particular, students indicated satisfaction with the way material was explained, the level of interest and enthusiasm demonstrated by the instructor, and their ability to openly express their opinions in the class. Student comments further revealed that the lecture and discussion formats, the openness of the discussions, and level of interaction in the course were enjoyable. Although student scores indicated that class materials or activities assisted in their learning, these two areas scored lower. One explanation, based on student comments, was their belief that there should be fewer activities in the course; an activity specifically noted was the role-play scenarios. Interestingly, although student evaluations from the previous course offering also supported that the workload in the course was high, role-plays were listed as a favorite activity. Future offerings may assist in clarifying this issue.

Course outcomes

Most of the course activities and elements successfully achieved students’ objectives for learning. Facilitated discussions that used the Think-Pair-Share methodology resulted in higher student participation. During the previous course offering, it was difficult to convince students to share their own experiences during group discussions. However, with the incorporation of active learning during the second course offering, approximately 80% of the class offered at least one comment during each discussion without prompting from the instructor. This is compared with 50% to 60% participation in the previous year, which was only achieved after multiple reminders by the instructor. Literature evaluations were also more successful. More students were prepared for and actively engaged in the activity. This was evident by the thoughtful and probing questions about the articles presented, fair evaluations of fellow classmates, and the supporting documentation to back up their assessments. In the past, only the student teams presenting the literature evaluation were visibly prepared and engaged in the discussion. In addition, the peer/self-evaluation helped to ensure that all students understood that they were expected to contribute to the team’s efforts on each project. Although only anecdotal evidence, there were no students who reported inactivity or a lack of contribution among group members. Finally, group reflections as well as final examination scores indicated that students’ understanding of the appropriateness, timing, and methods of spiritual integration into patient care were much clearer. Incorporation of the reflection activity and more focused discussion, with objectives listed for each role-play, further assisted their learning.

Based on student feedback, the timing and distribution of course activities should be reconsidered. By the nature of the course’s design, most activities and assignments were back-loaded into the second half of the course. Although this design was intentional because it allowed for conceptual foundations to be laid and time for students to complete the readings, it made the last seven weeks of the course busy. One way to address this might be to create and videotape role-play scenarios that would be reused annually. This would decrease student workload in the course while still maintaining the learning outcomes associated with the activity. In addition, it would relieve the “theater” aspect of the course, which some students found trying. Finally, student perceptions of workload could be managed through a couple of methods. The required reading assignment could be split up over the first six weeks. In addition, the final examination could be reformatted so it could be administered during class time rather than as a take-home essay.

In addition to the changes listed above, there are a few other limitations to the design of the course. First, the course was an elective limited to only 25 students. Although the size of the class promoted meaningful discussion and facilitated student active engagement, it would be difficult to adapt these methods to a larger class size. In addition,

although this course was and can be managed and presented by one instructor, it is logistically heavy and requires a lot of pre-class planning. Finally, because there has been no follow-up with students who elected to complete the course, to date there are no data on the real-world outcomes of the course on demonstrated abilities in identifying patients with spiritual issues, effectively engaging patients on spiritual issues, or acquiring a spiritual history.

Conclusions

Over the past several decades, there has been an increased interest in the relationship among religion, spirituality, and health care. As such, this elective course was developed and implemented to expose students to this additional aspect in care. The course focused on the conceptual foundations of the role of spirituality in patients' health, the primary literature supporting this relationship, and the development and performance of methods in which to appropriately incorporate spiritual assessment and care into pharmacy practice. Various teaching methodologies and assessment techniques were used to assist students in their learning. Instructor assessment of student performance indicated that the students comprehended and achieved the course outcomes. In addition, student evaluations indicated their enjoyment of the course, as well as their confidence in understanding the role of spirituality in health care. Given the important role spirituality plays in patient care, as well as the positive student response education and training in this field receive, more schools of pharmacy should consider incorporating a course, such as the one presented in this article in their curriculums.

Appendix 1: Presented Literature Evaluation Articles

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