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## Why “Spirituality” Instead of “The Humanistic Side of Medicine”?

**To the Editor:** In a recent commentary, Puchalski et al<sup>1</sup> describe the developing field of “spirituality” and its expansion into health professions education. However, we question whether this promotion really reflects an improvement.

According to Puchalski et al,<sup>1</sup> spirituality “encompasses individuals’ search for meaning and purpose; it includes connection to others, self, nature, and the significant or sacred; and it embraces secular and philosophical, as well as religious and cultural, beliefs.” Later in the commentary, the authors present another definition to which Puchalski also has contributed: “spirituality as an individual’s search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism and the arts.”<sup>2</sup> In the same commentary we are presented with two different definitions, both of which are based on abstract meta-concepts. A crucial question thus presents itself: What is left outside of spirituality? A prerequisite for a meaningful concept is that it is demarcated in relation to other concepts. Puchalski and colleagues’ conceptualization of spirituality lacks this demarcation—it unfortunately qualifies as an example of what Sartori called “conceptual stretching.”<sup>3</sup> It becomes a popular catch-all term—it means everything and, therefore, nothing.

Puchalski et al<sup>1</sup> report that by 2011, more than 75% of medical schools had “integrated spirituality-related topics into their training programs.” But, since spirituality appears to encompass everything outside of pure biomedicine—it actually seems surprising that this number is not 100%!

At medical education conferences, like AMEE, one can observe that professional identity formation (PIF) is one of the top

issues in today’s medical schools. Even if there are local differences, PIF typically encompasses medical psychology (crisis, trauma), social psychology (ethnicity, gender, culture, and group processes), medical ethics, discussions around death and dying, communication skills training, reflection groups for discussing personal experiences, and reflective writing to enhance self-awareness.<sup>4</sup> A common conceptualization for this content is “the humanistic side of medicine.” It seems that Puchalski et al would label it all “spiritual.”

In what sense then is the label of spirituality a contribution to the field—why is it not sufficient to talk about the humanistic side of medicine? In our mind, launching a concept in the absence of conceptual coherence, theoretical rationale, and systemic meaning causes more confusion than clarification.

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### In Reply to Salander and Hamberg:

The authors question the broad definition of spirituality and whether spirituality and health is a new field. We would assert that, although there is some overlap between spirituality, humanistic practice, and other related concepts in health care, there are important distinctions.

The definition of spirituality used in clinical care and in medical education is intentionally broad to be inclusive of the diverse ways people understand transcendent meaning in their lives. In several consensus conferences, experts in clinical care and medical education agreed that spirituality is an essential aspect of humanity and that spirituality encompasses individuals’ “search for meaning and purpose and their connectedness to others, self, nature, and the significant or sacred”; it embraces secular, humanist, and philosophical, as well as religious and cultural beliefs.<sup>1</sup>

Definitions of humanistic practice similarly are broad. The Gold Foundation definition is “infusing and sustaining our healthcare system with a culture of compassion, caring, and respect for patients and practitioners ... [practicing] patient-centered care by modeling the qualities of integrity, excellence, compassion, altruism, respect, and empathy.”<sup>2</sup>

Clearly there is considerable overlap between the definitions of humanism and spirituality. This is not surprising since both share a common goal: the provision of compassionate care. Humanistic practice and spirituality in health, however, are also different. Humanistic care addresses patients’ biopsychosocial concerns and values any other concerns important to the patient. Spirituality in health care focuses more on the inner life of the patient, the deeper aspects of what gives patients’ (and practitioners’) lives meaning and connectedness. Spirituality in health care also distinguishes itself by creating clinical teams, which include specialist spiritual care professionals such as certified chaplains, who define their work in keeping with the broad definition of spirituality to include all patients—religious, atheist, secular humanistic, and others.

Major health care organizations have endorsed the special role of spirituality and health in addressing the deeper aspects of patients’ inner lives. Within palliative care, for example, spirituality is a required domain of care and an equal aspect of the biopsychosocial and spiritual model of care.<sup>3,4</sup> The Joint Commission, which accredits most U.S. acute care hospitals, requires that all patients be asked about spiritual or religious issues and that hospitals assess and reassess patients for spiritual distress.<sup>5</sup>

We believe the scholarly and clinical advances that have contributed to the creation of this new field are making a significant impact in the provision of compassionate, whole-person care. The beginnings of the field of spirituality and health have allowed the scientific inquiry and discourse that will lead to more specific definitions, tested screening and assessment tools, and taxonomies and treatment protocols for spiritual distress.

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## Multiplying Adult Learning: A Consideration of Two Important Models

**To the Editor:** In the March issue, Wiseman et al<sup>1</sup> describe an interesting approach to teaching and learning rooted in establishing a safe learning climate. Kaufman<sup>2</sup> also emphasized

the concept of safe learning among other adult learning principles as the underlying foundation to establishing an effective teaching and learning environment. Wiseman et al propose a new model of clinical leadership focusing on “Multiplier” physician teachers, who “amplify intelligence, produce better outcomes, and grow talent”<sup>1</sup> on the health care team. Although this model is addressed to leaders in medical education, it really applies to all faculty who assume teaching responsibilities. As I reflected on this model, I immediately thought about adult learning and how known principles of adult learning interact with the concept of Multipliers.

Adult learning principles that complement Wiseman and colleagues’ model include the following:

- Considering everyone on the team to be a learner, some more senior than others,
- Reducing hierarchy by giving everyone permission to contribute to learning, from students up to faculty,
- Cultivating joint understanding of and responsibility for the entrustable professional activities in the context of the rotation,
- Knowing learners’ first names,
- Using “I” statements to affirm that the teacher has been in the learner’s shoes at some point and understands his or her difficulty, and
- Informing the learner about likely kinds of patient problems he or she will encounter.

The importance of combining the Multiplier and adult learning models is that *both* address ways to enhance the teacher–learner relationship, activate learners, and diminish the hierarchy between faculty and learners that exists in our academic health centers. Whatever methods help us transform the traditional teacher-centered model to a learner-centered approach will enhance the breadth and depth of learning.<sup>3</sup>

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**In Reply to Greenberg:** As Dr. Greenberg presents in his letter, the principles of adult learning are important considerations for developing a more effective leadership curriculum in academic medicine. The principles of adult learning Dr. Greenberg cites are also consistent with the findings from the research I have conducted on leaders who serve as “Multipliers” to a team (prompting people’s best work).

In particular, my colleagues and I found that “intellectual curiosity” was the top characteristic of Multiplier leaders. Those who exemplify intellectual curiosity learn from all sources—those across and below them in the hierarchy. We also found that the single greatest determinant for creating a culture of experimentation and learning was the leader’s willingness to talk openly about his or her own mistakes. Interestingly, we also found that “sense of humor” was a top characteristic of Multiplier leaders and the characteristic most negatively correlated with Diminisher leaders. The Multiplier leaders were not cracking jokes; rather, they did not take themselves too seriously and provided levity in artificially tense situations. Reducing anxiety allowed those on their team to minimize intellectual distraction and concentrate their mental energies on learning and performing.

As Dr. Greenberg suggests, we need our medical schools to be based on principles of adult learning. When leaders are true learners, it sets the aspiration (and the possibility) for the levels of learning and performance we expect from our physicians in training.

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