Religiosity and Spirituality of Resident Physicians and Implications for Clinical Practice—the SBRAMER Multicenter Study

Ana Paula Sena Lomba Vasconcelos, MSc[1],
Alessandra Lamas Granero Lucchetti, MD, PhD[1],
Ana Paula Rodrigues Cavalcanti, PhD[2],
Simone Regina Souza da Silva Conde, MD, PhD[3], *Lidia Maria Gonçalves, MD*[4],
Filipe Rodrigues do Nascimento, MD[5], *Ana Cláudia Santos Chazan, MD, PhD*[6],
Rubens Lene Carvalho Tavares, MD, PhD[7], *Oscarina da Silva Ezequiel, MD, PhD*[1], *and*
Giancarlo Lucchetti, MD, PhD[1]

[1]School of Medicine, Universidade Federal de Juiz de Fora, Av. Eugênio do Nascimento s/no. Bairro: Dom Bosco, Juiz de Fora, Brazil; [2]Department of Religious Sciences, Universidade Federal da Paraíba, João Pessoa, Brazil; [3]School of Medicine, Universidade Federal do Pará, Belém, Brazil; [4]School of Medicine, Universidade de São Paulo, São Paulo, Brazil; [5]School of Medicine, Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil; [6]School of Medicine, Universidade do Estado do Rio de Janeiro, Rio de Janeiro, Brazil; [7]School of Medicine, Universidade Federal de Minas Gerais, Belo Horizonte, Brazil.

OBJECTIVES: To assess the attitudes, knowledge, and experiences of Brazilian resident physicians regarding religiosity/spirituality (R/S), factors associated with addressing this issue, and its influence on clinical practice.
METHODS: We report results of the multicenter "Spirituality in Brazilian Medical Residents" (SBRAMER) study involving 7 Brazilian university centers. The Network for Research Spirituality and Health (NERSH) scale (collecting sociodemographic data, opinions about the R/S-health interface, and respondents' R/S characteristics) and the Duke Religion Index were self-administered. Logistic regression models were constructed to determine those factors associated with residents' opinions on spirituality in clinical practice.
RESULTS: The sample comprised 879 resident physicians (53.5% of total) from all years of residency with 71.6% from clinical specialties. In general, the residents considered themselves spiritual and religious, despite not regularly attending religious services. Most participants believed R/S had an important influence on patient health (75.2%) and that it was appropriate to discuss these beliefs in clinical encounters with patients (77.1%), although this was not done in routine clinical practice (14.4%). The main barriers to discussing R/S were maintaining professional neutrality (31.4%), concern about offending patients (29.1%), and insufficient time (26.2%). Factors including female gender, clinical specialty (e.g., internal medicine, family medicine, psychiatry) as opposed to surgical specialty (e.g., surgery, obstetrics/gynecology, orthopedics), having had formal training on R/S, and higher levels of R/S were associated with greater discussion of and more positive opinions about R/S.
CONCLUSION: Brazilian resident physicians held that religious and spiritual beliefs can influence health, and deemed it appropriate for physicians to discuss this issue. However, lack of training was one of the main obstacles to addressing R/S issues in clinical practice. Educators should draw on these data to conduct interventions and produce content on the subject in residency programs.

KEY WORDS: spirituality; religion and medicine; resident physicians; medical education; graduate students; medical residents.

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INTRODUCTION

The interface between religiosity/spirituality (R/S) and health has long been recognized and studies on the subject have grown steadily in recent years.[1, 2] Scientifically, the need to standardize R/S terms used in research has called for a conceptual analysis to clarify understanding and differences between spirituality and religion. According to Harold Koenig,[3] religion is an organized system of beliefs, practices, rituals, and symbols designated to aid access to the sacred and transcendent, while spirituality is defined as the personal search to understand issues involving end of life, its meaning, and relationships with the sacred or transcendent that may or may not lead to the development of religious practices or the formation of religious communities.

The growing number of studies in the area, together with ethical and professional guidelines based on patient-centered care, has promoted the introduction of programs on spirituality

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and health into the curricula of many universities. Currently, this content exists in the curriculum of 90% of North American,[4] 59% of British,[5] and 40% of Brazilian[6] medical schools. Similarly, a number of societies and organizations, such as the American College of Physicians, the American Medical Association, the American Nurses Association, and the Joint Commission on Accreditation of Healthcare Organizations, have recognized the importance of the issue and recommend integrating R/S into clinical practice.[7]

Despite this evidence, most health professionals do not discuss the issue as part of routine clinical practice. A systematic review including over 20,000 physicians found that 16–32% of physicians routinely inquired about their patients' beliefs,[8] rates corroborated by other samples in which 10% of North American physicians,[9] 4.4% of Canadian, 25% of Indian, and 11.1% of Brazilian doctors often or always discuss the matter.[10]

This same pattern is observed in medical undergraduate training. Although 75% of trainees believed that spirituality had an important influence on patient health, they did not feel prepared to engage in this type of discussion, pointing to a lack of specific training during medical school.[11] Likewise, faculty did not feel fully prepared to deal with the subject, leading to deficits in students' and residents' training.[12, 13]

Within the ambit of medical training, students and teachers have a clearly defined role in the teaching-learning process. However, resident physicians face a more complex situation, in which they act as both trainee and primary physicians caring for patients.[14] Residency is an important step in the future clinical practice of the professional physician, during which training on sensitive issues should be expanded. Moreover, the R/S issue is not widely implemented in residency programs, evidenced by the fact that only 31% of family medicine residency programs in the USA[15] and 28.5% of psychiatric residency training in Canada[16] incorporate compulsory activities involving R/S. Although residents seem to have greater exposure to R/S during their training as compared with medical students,[17] several barriers to incorporating these issues into clinical practice remain, such as insufficient time, lack of training, and concerns about offending patients. Previous studies have shown that these barriers could be minimized by providing appropriate R/S training in residency programs.[18–20]

Within this context, relatively few papers have discussed resident attitudes on R/S, and those available involve only single centers and small, poorly representative samples.[18–23] The present study addresses this gap, assessing a large sample of Brazilian resident physicians from multiple institutions. Therefore, the objective of the present study was to assess the attitudes, knowledge, and experiences of Brazilian resident physicians regarding religiosity/spirituality (R/S), factors associated with addressing the issue, and its influence on clinical practice.

METHODS

A cross-sectional, multicenter, observational study with a quantitative design was carried out between July 2017 and July 2018, coordinated by the Federal University of Juiz de Fora, Brazil, and involving 7 Brazilian university centers responsible for training resident physicians (Supplementary Table 1). The project was approved by the Ethics Committee of the Federal University of Juiz de Fora under permit number CAAE 57905716.4.1001.5133 and by the other participating centers. All study participants signed an informed consent form.

All physicians undertaking residency programs at the university centers listed were eligible to participate, giving an eligible study population of 1642 resident physicians. For inclusion, residents had to be officially registered on the residency program and had to be participating in the educational or medical activities of this program. Residents participating in out-of-town rotations, who were on vacation, or had suspended their training course due to medical leave or work absence were not included. The residents were approached by trained researchers (teachers, students, or other residents) at the workplace during the day, when not attending to patient care, and were invited to complete the survey.

The questionnaire was self-administrated and took around 20–30 min to complete and comprised the following:

- Network for Research Spirituality and Health (NERSH) scale: this is the updated version of the survey "Religion and Spirituality in Medicine: Physicians' Perspectives" (RSMPP) developed by Curlin et al. in 2002[24] and validated by a pool of experts in a previous study.[25] The NERSH questionnaire, which is available upon request, included 3 sections: A, (10 questions collecting demographic data including gender, age, marital status, religion, and data characterizing the residency such as specialty and year of residency program); B, (19 questions on views regarding the R/S-health interface); and C, (18 questions on respondents' R/S characteristics). The Portuguese version was translated by health professionals (researchers) involved in the present study (2 physicians and 1 psychologist) and back-translated into English by a native British translator. The original authors of the scale authorized its use and validated the back-translation. The original scale exhibited satisfactory psychometric properties, as did the Brazilian version.[26]

- Duke Religion (DUREL) Index: religiosity was also assessed by applying the DUREL index, a brief 5-item scale assessing 3 dimensions of religiosity: organizational religiosity (frequency of attending religious centers or meetings), non-organizational religiosity (frequency of spending time in private religious activities, such as prayer, scripture study, or religious meditation), and intrinsic religiosity (religion as an end). The DUREL scale was developed by Koenig[27] and has been validated for use in Brazil.[28]

Statistical Analysis

Descriptive statistics were used to describe sociodemographic and R/S characteristics, and their influence on clinical practice of resident physicians. For the inferential analysis, logistic regression models were constructed to determine those factors associated with residents' opinions on spirituality in clinical practice. To this end, the following independent variables were selected: gender, age, year of residency, prior formal R/S training, having a religion, religiosity (divided into high or low) and spirituality (divided into low and high), and medical specialty of residency (clinical versus surgical). For the present study, the following specialties and subspecialties were considered surgical: general surgery (e.g., general surgery, plastic surgery, urology, cardiovascular surgery), orthopedics, gynecology, obstetrics, ENT/otolaryngology, and ophthalmology. Clinical specialties were internal medicine (e.g., general medicine, cardiology, dermatology, neurology, geriatrics), pediatrics, anesthesiology, ICU, family medicine, radiology, oncology, and emergency medicine.

The independent variables used were dichotomized, for example: "Overall, how much influence do you think religion/spirituality has on patients' health? (1, Very much/Much; 0, Some/A little/Very little to none)".

All data were analyzed using the SPSS version 21 statistical package and a value of $p < 0.05$ was adopted as significant with a 95% confidence interval.

RESULTS

A total of 879 resident physicians (53.5% of total) were included from seven universities (Supplementary Material). The sample consisted of individuals who were predominantly women (61%), married or cohabitating (29.6%), and had a mean age of 28.09 years (SD: 3.35, range 23–46 years). Participants were from all years of residency (47.3% 1st year, 25.1% 2nd year, 17.7% 3rd year, 7.0% 4th year, 2.5% 5th year, 0.5% 6th year) and 71.6% pursued clinical specialties. The most common medical specialties were pediatrics (12.9%), internal medicine (12.6%), gynecology/obstetrics (10.3%), family medicine (8.6%), general surgery (8.0%), and anesthesiology (8.0%).

Concerning the personal religious characteristics of the sample, most residents believed in a higher power (88.0%); looked to God for strength, support, and guidance (81.0%); believed in a life after death (62.8%); had a religious or spiritual experience that changed their life (56.4%); and considered themselves very or moderately spiritual (69.8%) and very or moderately religious (57.5%). Despite these characteristics, only 22.1% attended religious services once a week or more, and 38.7% spent time in religious activities (Supplementary Material).

Resident physicians' opinions concerning the influence of R/S on health are shown in Table 1. Most residents believed R/S had an important influence on patient's health (75.2%) and on the healing process (60.5%) and this influence was considered generally positive (ranging from 42.9 to 81.8% depending on disease presented). Most residents reported they would feel comfortable discussing R/S concerns (78.5%), believed it appropriate to inquire about the patient's R/S (77.1%) and appropriate to pray with them (62.8%), and talk about their own beliefs when the patient asked (54.7%).

Table 2 presents the participants' use of R/S in clinical practice. Although most residents inquired about patients'/relatives' religious/spiritual issues (72.2%), this was not done on a regular basis (85.6%). The clinical scenarios in which physicians addressed this issue more frequently (i.e., often or always) were when patients faced end-of-life issues (52.2%),

Table 1 Resident Physicians' Opinions About the Spirituality/Religiosity-Health Interface

Resident physicians' opinions		*n*	%
Overall, how much influence do you think religion/spirituality has on patients' health?			
Much/Very much		660	75.2
Some/A little/Very little to none		218	24.8
Overall, how much influence do you think religion/spirituality has on patients' healing process?			
Much/Very much		531	60.5
Some/A little/Very little to none		346	39.5
In general, is it appropriate for a physician to discuss religious/spiritual issues when a patient/relative brings them up?			
Always appropriate/Usually appropriate		770	87.7
Usually inappropriate/Always inappropriate		108	12.3
In general, is it appropriate for a physician to inquire about a patient's/relative's religion/spirituality?			
Always appropriate/Usually appropriate		677	77.1
Usually inappropriate/Always inappropriate		200	22.9
When, if ever, is it appropriate for a physician to talk about his or her own religious beliefs or experiences with a patient/relative?			
Never		141	16.1
Only when the patient/relative asks		480	54.7
Whenever the physician senses it would be appropriate		256	29.2
When, if ever, is it appropriate for a physician to pray with a patient/relative?			
Never		128	14.7
Only when the patient/relative asks		548	62.8
Whenever the physician senses it would be appropriate		197	22.5
I would feel comfortable discussing a patient's/relative's religious/spiritual concerns if the patient/relative brought them up			
Strongly agree/Agree		688	78.5
Disagree/Strongly Disagree		189	21.5
Is the influence of religion/spirituality on the following illnesses generally positive or negative?			
(a) Psychiatric illnesses	Generally positive	376	42.9
	Generally negative	85	9.7
	Both positive and negative	393	44.8
	No influence	23	2.6
(b) Cancer	Generally positive	717	81.7
	Generally negative	5	0.6
	Both positive and negative	141	16.1
	No influence	14	1.6
(c) Chronic pain diseases	Generally positive	648	73.8
	Generally negative	12	1.4
	Both positive and negative	179	20.4
	No influence	39	4.4
(d) Cardiovascular diseases	Generally positive	495	56.6
	Generally negative	11	1.3
	Both positive and negative	207	23.7
	No influence	161	18.4

Table 2 Religiosity/Spirituality, Clinical Practice, and Main Barriers to Discussion

Resident physicians' opinions and practice		*n*	%
Do you ever inquire about patients'/relative's religious/spiritual issues?			
No		243	27.8
Yes		632	72.2
How often do you inquire?			
Never questioned/Rarely/Sometimes		749	85.6
Often/Always		126	14.4
How often have patients/relatives seemed uncomfortable when you inquire?			
Never questioned		243	27.8
Never/Rarely		574	62.7
Sometimes/Often/Always		83	9.5
How often do you inquire about religious/spiritual issues? When a patient/relative:			
(a) presents with a minor illness or injury	Never/Rarely/Sometimes	803	91.9
	Often/Always	71	8.1
(b) faces a frightening diagnosis or crisis	Never/Rarely/Sometimes	614	70.3
	Often/Always	261	29.7
(c) faces the end of life	Never/Rarely/Sometimes	416	47.8
	Often/Always	455	52.2
(d) suffers from anxiety or depression	Never/Rarely/Sometimes	649	74.2
	Often/Always	225	25.8
(e) comes for a medical history, physical exam	Never/Rarely/Sometimes	825	94.8
	Often/Always	46	5.2
(f) faces an ethical quandary	Never/Rarely/Sometimes	718	82.6
	Often/Always	151	17.4
When religious/spiritual issues come up in discussions with patients/relatives, how often do you respond in the following ways?			
I listen carefully and empathetically	Never/Rarely/Sometimes	89	10.3
	Often/Always	785	89.7
I try to change the subject in a tactful way	Never/Rarely/Sometimes	781	89.5
	Often/Always	92	10.5
I encourage patients in their own R/S beliefs/practices	Never/Rarely/Sometimes	375	42.9
	Often/Always	498	57.1
I respectfully share my own religious ideas/experiences	Never/Rarely/Sometimes	749	85.7
	Often/Always	125	14.3
I pray with the patient/relative	Never/Rarely/Sometimes	833	95.3
	Often/Always	41	4.7
Does anything discourage you from discussing religion/spirituality with patients/patients' relatives?			
No		546	62.5
Yes		327	37.5
Which of the following reasons discourages you?			
General discomfort with discussing religious matters		190	21.7
Insufficient knowledge/training		202	23.1
Insufficient time		229	26.2
Concern about offending patients/relatives		254	29.1
Concern that my colleagues will disapprove		52	6.0
Professional neutrality		274	31.4
Not my task		76	8.6
I refuse to speak of these matters in my work		17	1.9
Overall, do you think the amount of time you spend addressing religious/spiritual issues is			
Too much		22	2.5
Too little		558	64.3
The right amount		288	33.2

faced a frightening diagnosis or crisis (29.7%), and suffered from anxiety or depression (25.8%). Most residents listened carefully and empathetically to R/S issues brought up by patients (89.7%) and encouraged patients/relatives in their own religious/spiritual beliefs and practices (57.1%). A total of 37.5% reported that some issues discouraged them from discussing religion/spirituality (R/S), where the most common reasons were to maintain professional neutrality (31.4%), concerns about offending patients/relatives (29.1%), insufficient time (26.2%), insufficient knowledge/training (23.1%), and general discomfort with discussing this issue (21.7%).

Table 3 shows the factors associated with residents' opinions and practices concerning the addressing of R/S issues. Regarding participants' opinions, female residents having a religious affiliation and with higher levels of spirituality tended to believe more in the influence of R/S on patients' health. Likewise, residents that were younger, from clinical specialties, in the later phase of training, who had formal R/S exposure, and higher levels of religiosity tended to feel it is appropriate to discuss R/S issues when a patient/relative brought them up. Concerning their clinical practice, residents from clinical specialties, who had formal R/S training and with higher levels of spirituality, inquired more about R/S issues. Finally, residents with formal R/S training and high spirituality tended to feel more comfortable discussing R/S with patients/relatives. None of the variables was associated with having had formal training on addressing R/S in clinical practice.

DISCUSSION

The results of the present study showed that, in general, the resident physicians considered themselves spiritual and religious, despite not regularly attending religious services. Most participants believed R/S had an important influence on patient health and that it was appropriate to discuss these beliefs, although this was not done regularly in routine clinical practice. The main barriers reported were maintaining professional neutrality, concern about offending patients, and insufficient time. Factors including female gender, clinical specialty as opposed to surgical, having formal R/S training, and higher levels of R/S were associated with greater discussion and more positive opinions about the subject. These findings can serve to develop future educational interventions for this population and be of value to educators and residency programs.

With regard to residents' R/S, most participants considered themselves religious and/or spiritual and reported looking to God or a higher power for support and guidance. These results reflect the religious/spiritual nature of the Brazilian population, in which over 90% have a religious affiliation and consider religion important in life.[29] However, residents tended to attend fewer religious services than the general population, possibly due to lack of time available for this activity. This characteristic of higher religiosity and spirituality of Brazilian resident physicians differs from medical populations in European countries such as Germany and Denmark, but mirrors R/S profiles in the USA and India.[30]

Table 3 Factors Associated with Opinions on the Religiosity/Spirituality-Health Interface

	OR	95% CI OR	p
Overall, how much influence do you think religion/spirituality has on patients' health? (1, Very much/Much; 0, Some/A little/Very little to none)			
Female gender	1.898	1.345–2.697	*< 0.001*
Age	1.012	0.959–1.068	0.653
Clinical specialty	0.974	0.670–1.417	0.892
Year of residency	0.934	0.800–1.091	0.388
Formal R/S training	0.784	0.483–1.272	0.325
Have a religion	1.332	1.087–1.634	*0.006*
High religiosity	1.114	0.713–1.740	0.636
High spirituality	2.231	1.435–3.468	*< 0.001*
In general, is it appropriate for a physician to inquire about a patient's/relative's religion/spirituality? (1, Always appropriate/Usually appropriate; 0, Usually inappropriate/Always inappropriate)			
Female gender	1.251	0.880–1.778	0.212
Age	1.035	0.978–1.095	0.238
Clinical specialty	2.336	1.643–3.321	*< 0.001*
Year of residency	0.946	0.809–1.107	0.488
Formal R/S training	1.311	0.766–2.245	0.323
Have a religion	1.003	0.827–1.216	0.975
High religiosity	1.567	1.012–2.425	*0.044*
High spirituality	0.945	0.598–1.494	0.489
In general, is it appropriate for a physician to discuss religious/spiritual issues when a patient/relative brings them up? (1, Always appropriate/Usually appropriate; 0, Usually inappropriate/Always inappropriate)			
Female gender	0.843	0.543–1.331	0.464
Age	0.919	0.867–0.974	*0.005*
Clinical specialty	2.128	1.358–3.335	*0.001*
Year of residency	1.299	1.048–1.612	*0.017*
Formal R/S training	4.110	1.464–11.541	*0.007*
Have a religion	1.088	0.849–1.394	0.504
High religiosity	1.923	1.112–3.326	*0.019*
High spirituality	0.951	0.542–1.669	0.861
Do you ever inquire about patients'/relative's religious/spiritual issues? (1, yes; 0, no)			
Female gender	1.054	0.755–1.470	0.759
Age	1.020	0.969–1.073	0.445
Clinical specialty	1.749	1.246–2.454	*0.001*
Year of residency	1.086	0.933–1.263	0.287
Formal R/S training	1.688	0.999–2.854	0.051
Have a religion	1.069	0.889–1.284	0.479
High religiosity	0.880	0.574–1.350	0.558
High spirituality	2.064	1.334–3.192	*0.001*
How often do you inquire about patients'/relative's religious/spiritual issues? (1, Often/Always; 0, Never/Rarely/Sometimes)			
Female gender	1.320	0.843–2.068	0.225
Age	1.019	0.959–1.083	0.541
Clinical specialty	0.933	0.580–1.500	0.774
Year of residency	1.055	0.877–1.269	0.568
Formal R/S training	2.974	1.791–4.940	*< 0.001*
Have a religion	1.056	0.837–1.333	0.647
High religiosity	1.345	0.789–2.291	0.276
High spirituality	0.908	0.506–1.627	0.745
I would feel comfortable discussing a patient's/relative's religious/spiritual concerns if the patient/relative brought them up (1, Strongly agree/Agree; 0, Disagree/Strongly disagree)			
Female gender	0.971	0.671–1.407	0.877
Age	1.016	0.960–1.076	0.580
Clinical specialty	1.049	0.710–1.551	0.809
Year of residency	1.119	0.941–1.330	0.203
Formal R/S training	3.905	1.837–8.305	*< 0.001*
Have a religion	1.164	0.946–1.431	0.151
High religiosity	1.476	0.932–2.338	0.097
High spirituality	1.871	1.185–2.952	*0.007*
Have you had any formal training regarding religion/spirituality in medicine? (1, yes; 0, no)			
Female gender	0.931	0.600–1.445	0.750
Age	1.005	0.942–1.072	0.881
Clinical specialty	1.183	0.732–1.911	0.493
Year of residency	0.972	0.797–1.185	0.779
Have a religion	0.977	0.768–1.243	0.850
High religiosity	0.952	0.549–1.652	0.952
High spirituality	0.893	0.504–1.580	0.697

Significant at p<0.05

The current findings that most residents believed R/S influences health and that discussing this is appropriate in different clinical contexts are corroborated by studies of other populations involving physicians,[10, 24, 31] medical students,[11] residents,[18, 22] and other health professionals.[32] Despite this positive perception, few professionals discuss patients' R/S in clinical practice,[8, 23] where most residents reported not holding sufficient knowledge to take a spiritual history.[18] In the present study, although 72.2% had inquired about patients' beliefs, only 14.4% did so on a routine basis, a result consistent with previous studies reporting rates ranging from 10 to 32%.[8–10] The main barriers reported by the resident physicians encompassed those commonly cited by students, such as concern about offending patients and insufficient training,[11] and by practicing physicians, such as desire to maintain professional neutrality and insufficient time.[31]

A variety of factors were associated with more positive opinions on the issue. Women perceived greater influence of R/S on clinical practice, perhaps explained by the fact that women have more religious beliefs than men and a tendency to provide more holistic patient-centered care.[33] Residents that had higher religiosity and/or spirituality also tended to hold stronger beliefs that R/S influenced health, felt it was more appropriate to discuss the issue, and were more comfortable addressing it and inquiring about patients' R/S. These results suggest that having a belief helped residents discuss R/S because they were more familiar with the issue and willing to address it. However, physicians' beliefs can act positively or negatively on treatment and patient management, depending on the approach adopted.[34] Thus, students should be trained to refrain from imposing their own beliefs and learn how and when these values support professional and patient-centered care, and when they do not.[30]

Another factor associated with residents' views was type of specialty undertaken. The present findings showed that residents pursuing clinical specialties, as opposed to surgical specialties, believed it more appropriate to discuss and inquire about the matter. Similar results were found in a survey of 1144 North American physicians,[35] which revealed that surgeons tended to discuss this issue less in clinical practice.[36] This difference can be partially explained by the fact that surgeons receive less training compared with other specialties.[35] Another possible reason for this result is that the decision to pursue a clinical specialty is generally influenced by an individual's higher religiosity. However, a previous study found no differences between clinical and surgical specialties on this matter.[37]

Lastly, previous formal R/S training was associated with believing it more appropriate to discuss, inquire about, and feel comfortable with addressing the issue. Educational interventions have proven effective not only in improving knowledge, attitudes, skills, and professional practice but also for reducing the barriers to discussing this issue.[18–20, 38, 39] Previous studies have shown that incorporation of an R/S curriculum improved knowledge concerning the role of chaplains (but not attitudes and skills) in internal medicine residents,[18] reduced worries related to spiritual care, was associated with

better attitudes and skills in family medicine residents,[19] and also increased the competency and incorporation of R/S in clinical practice among psychiatry residents.[20]

Given the fact that only 16–32% of health professionals address R/S issues in clinical practice,[8] that most patients (70%) believe it appropriate for doctors to enquire about spiritual needs,[40] and that most residency programs do not yet incorporate formal compulsory training on the subject,[14, 15] greater priority should be placed on R/S training in residency programs, both in training preceptors and educating residents, toward providing more integrative, holistic, and patient-centered care.

The present study has some limitations which should be considered when interpreting results. First, the study involved Brazilian resident physicians, a group with highly specific cultural aspects. Thus, this study should be replicated in other countries and settings. Secondly, although our sample is larger than those of other studies investigating the issue in resident physicians and the response rate was deemed satisfactory, the study population comprised predominantly women (61%), corroborating recent data showing a trend toward the "feminization" of medicine in Brazil.[41] However, women may have been more willing to answer the questionnaire owing to the subject of R/S. Thirdly, the NERSH scale, although widely used around the world, measures only respondents' perceptions, attitudes, and opinions. These aspects are subject to social desirability, as noted in a previous study that found social desirability bias may influence religious orientations, religious coping, and daily spiritual experiences.[42] Therefore, it is not possible to verify whether these attitudes translate to clinical practice during medical visits.

In conclusion, Brazilian resident physicians believe that religious and spiritual beliefs can influence health and deem it appropriate for physicians to discuss the issue. However, lack of training remains one of the main obstacles to addressing R/S issues in clinical practice. Educators should draw on this data to conduct interventions and produce compulsory content on the subject in residency programs.

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Corresponding Author: *Giancarlo Lucchetti, MD, PhD; School of Medicine, Universidade Federal de Juiz de Fora, Av. Eugênio do Nascimento s/no. Bairro: Dom Bosco, Juiz de Fora 36038-330, Brazil (e-mail: g.lucchetti@yahoo.com.br).*

Compliance with Ethical Standards:

The project was approved by the Ethics Committee of the Federal University of Juiz de Fora under permit number CAAE 57905716.4.1001.5133 and by the other participating centers. All study participants signed an informed consent form.

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