

Challenges of Developing Religious Competencies in Medical Education in Iran: A Qualitative Study

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Abstract

Background and Objectives: Competency-based medical education focuses on empowering the medical students with capabilities required to act effectively in their field work, in accordance with the needs and demands of the service sector. The remarkable rise in the interconnection between medicine and religious issues in recent years has intensified the need to addressing religious competencies in medical education. However, there is little evidence of such a tendency in the Iranian medical universities. We investigated the barriers and challenges faced by medical education system for the development of religious competencies.

Methods: This qualitative study was carried out by conventional content analysis method. The participants were 18 faculty members and instructors from 7 Iranian medical universities, selected through purposeful sampling. The experts' opinions were obtained through deep semi-structured interviews and analyzed by MaxQDA (version 10).

Results: The results revealed the challenges of developing religious competencies in five main categories including conceptual challenges (lack of clarified concept of religious competencies, and the predominance of secular approach), motivational challenges (lack of intrinsic/ extrinsic motivation), methodological challenges (lack of appropriate teaching/ learning methodology and inadequacy of assessment mechanisms), institutional challenges (the absence of supportive and facilitating organizational culture, lack of necessary infrastructures, discordant content and resources, and improper policies), and finally contextual challenges (sociocultural conflicts and macro social structures).

Conclusion: Religious competencies development in Iranian medical education is in need of close attention to multiple factors affecting it, some of which are outlined in this article. It seems that a multifaceted look is needed for a comprehensive plan in this regard.

Keywords: Medical Education, Religion and Medicine, Spirituality, Iran.

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Introduction

Competency-Based Medical Education (CBME) concentrates on identifying the required abilities of the graduates through analysis of community and patients' needs and their fulfillment in a flexible and learner-centered manner (1) and redesigning the curricula in a multidimensional, dynamic, developmental and contextual approach (2) to ensure the capabilities necessary for an effective healthcare service to the target community. In competency-based education, the curricula are designed by prospective analysis of the actual roles of the graduates in

modern societies, trying to ensure the learner's acquirements on the basis of their represented functions in all or parts of that dimensions (3). Thus, CBME is a mechanism to align the goals of educational programs with the needs of patients and provide desirable services for them (1). In this way, it is necessary to monitor the emerging needs and demands with the aim of adapting with them.

Acceptance of spiritual health as a dimension of health has led to an attention to spirituality as an important issue in health care while on the other hand, the undeniable overlap of

religion and spirituality has underscored this need in the framework of holistic view to human beings. As a result, many health care providing systems have focused on the religious/ spiritual desires, interests, and opinions of their patients and consequently, religious/ spiritual material have been included in educational programs of medical education institutes (4).

The significance of religious attitude in physicians' clinical decision-making (5,6), the role of personal values of patients in their treatment choices (7), the interconnectedness of religious behaviors and rituals with decreased physical and mental disorders (8), the association of religiosity with healthy life-style and avoidance from life-threatening high-risk behaviors (9), the relationship between religion/ spirituality and coping with severe illnesses as well as the significance of ethical and ritual aspects of religion on patients (10) are among the main reasons and evidences listed for the necessity of addressing religious/ spiritual issues. In other words, it seems impossible to guarantee human health without the involvement of spirituality. Otherwise, the health system cannot avoid reductionism, oversimplification, and one-sidedness to human issues.

Thus, to provide holistic and satisfactory services, health care providers need capabilities to meet the religious/spiritual needs of the patients, referred to as religious/spiritual competencies (11,12), which means recognition, acceptance and appropriately addressing the religious needs of the patients so that, while taking into account their inner needs, provide the grounds for performing their rituals and religious deeds along with maintaining their human dignity and provoking and activating their religious tendencies as a source for the promotion of satisfaction, recovery and treatment (13).

In addition to developing standards of religious and spiritual competencies of psychologists and counselors, addressing the components of religion, spirituality, beliefs and cultural values of individuals and their personal preferences in designing and providing health services (14), have led to the considering religious

perspective in clinical care as a part of the expected competencies of physicians in various educational institutions (15), and in the curricula of general medicine, postgraduate and continuing medical education courses (13). The above-mentioned trend has left a significant impact on the attitude of physicians in accepting this overlooked part of their profession. Nevertheless, due to barriers such as lack of knowledge and skills and inadequate training, there is a long way to go to achieve the desired outcomes (11,12,16-18). This deficiency and the need to resolve it is well understood in the Iranian medical education system. Therefore, this study was an attempt to contemplate on the experts' opinions regarding the development of religious competencies in medical students' training programs, focusing to answer the following question: Despite the perceived necessity of systematically addressing the religious competencies in the medical education according to the literature reviewed and the existing empirical evidences, what are the challenges faced in the route of developing these competencies in Iranian medical education?

Methods

This study, aiming to address barriers to the development of religious competencies in Iranian medical education system, was a qualitative study of conventional content analysis approach. The advantage of this approach is to obtain direct information from the participants without imposing any predetermined categories (19). For this end, a purposeful sampling was used in which people with rich experience in the issue under study and meeting the inclusion criteria, including activity in the field of medical education and the tendency towards religious issues were identified. The participants were faculty members and instructors from Qom, Tehran, Iran, Shahid Beheshti, Mashhad, Tabriz, and Qazvin universities of medical sciences.

Data collection was carried out through in-depth interviews, using semi-structured interview guide, derived from literature review. Accordingly, each interview began with a general question about the concept in

question and trying to reach a common understanding of what was meant by religious competencies. The interviews continued focusing on the participants' opinions about the components, merits, and outcomes as well as the prerequisites, facilitators, and barriers of developing religious competencies. Further questions considered the participants' assessment of the current status of addressing religious competencies in Iranian medical schools curricula. In the interview process, more exploratory questions were put forth based on the participants' responses. The interviews continued until data saturation, that is when it was found that further interviews do not lead to new codes (20). Each interview lasted between 30 to 75 minutes, being recorded with the participant's consent and fully rewritten after the end of each interview. To keep the consistency, one person administered the interviews and transcribed them all.

For qualitative data analysis, MaxQDA 10 was used. For this purpose, the typed transcripts of the interviews were entered into the software and reviewed several times. The result was the extraction of semantic units and assigning open codes to the pieces of the text. After the entire interviews being analyzed, the codes were summarized to form the subcategories, and finally were more abstracted to formulate the main categories.

To ensure the accuracy and robustness of the findings, peer check and member check techniques were used. Furthermore, the ethical considerations including the participants' consent to audio record of the interviews and observing the qualitative research principles to ensure the accuracy, validity and reliability of the study were considered.

Result

The study was composed of interviews with 18 experts, including 11 physicians, three pharmacologists, two nursing, one midwifery, and one complementary medicine graduates. The clinicians' specialty or subspecialty included internal medicine, pulmonology, orthopedics, psychiatry, legal medicine, and community medicine. Furthermore, a number

of the participants had additional degrees in different fields of study such as medical ethics, future study, medical education, religion studies, and Islamic studies in religious seminaries. In terms of academic degree, the participants consisted of four professors, three associate professors, seven assistant professors, and four without academic degrees, each of them with at least five years of activity in the field of medical education; theoretical or practical. Six women and 12 men within the age range of 40 to 63 years participated in this study.

After analyzing the data, participants' opinions were classified into five main categories, 12 sub-categories and 60 concepts (table 1).

Findings of this study identified the challenges of developing religious competencies in Iranian medical education within five main categories including conceptual, motivational, methodological, institutional, and contextual challenges, which are illustrated as follows.

1. Conceptual challenges: Any step directed to the development of religious competencies requires an explanation of the concept to its stakeholders in order to clarify the direction of subsequent steps and the destination. Non-clarified concept of religious competencies and the predominance of the secular approach, form the conceptual challenges pointed out by the participants. Non-clarification refers to a missing agreed-upon definition by all the parties involved in medical healthcare and medical education as a basis to build upon the model of developing religious competencies, while on the other hand, the hegemonic authority of secular outlook gives little space for alternative issues.

"Our physicians are not aware of the effects of religion on health, because they have educated within a biological paradigm framework. You should change this paradigm. I mean you plan another education system on the basis of a humanistic paradigm. Otherwise, you should be able to translate the religious concepts to objective concepts that he can see its outcomes objectively and biologically. If

Table 1: challenges of developing religious competencies in Iranian medical education

Main Categories	Sub-categories	Concepts
Conceptual challenges	lack of clarified concept of religious competencies	Lack of clarification of the concept and components of religious competence \ Lack of understanding on the nature, necessity and consequences of religious competence\ Poor knowledge of the relationship between religion and medical profession\ Lack of rational and efficient discourse on the use of religion and religious resources in the field of health
	predominance of secular approach	Regarding the moral virtues as independent and isolated from religion\ Missing religion-based anthropology in medical education\ Lack of holistic view taking into account soul and its effects on the body\ Imperfect understanding of religion and spirituality\ Viewing ethics as a component of professionalism, citizenship, not religious – spiritual\ Non-religious foundations of health and medical education
Motivational challenges	Lack of intrinsic motivation	Unfelt necessity of religious competencies and their effects on health system\ Unperceived challenges of lack of religious competencies\ False sense of saturation and indifference to concepts such as religion and spirituality
	Lack of extrinsic motivation	Non priority of religious competencies in health system programs\ Negligence of health system from the advantages of religious competencies as a competitive advantage\ Lack of explicit demand from patients and clients\ Indeterminacy of ethical and human virtues as criteria of university outputs\ Not established referral system of religious or spiritual interventions.
Methodological challenges	lack of appropriate teaching and learning methodology	Lack of interdisciplinary and trans-disciplinary approach to medical education\ Not agreed upon methodology for developing religious competencies\ Lack of knowledge management to record and share successful experiences\ Inefficient interaction between active groups and individuals\ Implicit influence of the instructors' behavior and performance through hidden curriculum.
	inadequacy of assessment mechanisms	Inappropriateness of current evaluation system for religious competencies\ Inconvenience of assessing religious competencies\ Possible damages and unintended consequences of scoring religious competencies.
Institutional challenges	absence of supportive and facilitating organizational culture	Trivial contribution of universities in creativity, innovation and knowledge production\ Alienation from the production of religious knowledge\ Detachment from native cultural heritage and passivity and being impressive to Western teachings\ Lack of critique of exotic learning content and material\ Dominance of biomedical paradigm on the health system\ Physicians' cognitive error towards patients and rights\ insufficient knowledge and intolerance of the medical community for diverse knowledge\ The isolation of universities from the community\ Limited freedom and independence of universities\ Disappointment and hopelessness among students\ Influence of religiously nonqualified counterparts.
	lack of necessary infrastructures	Failure to meet basic needs as a prerequisite for addressing more transcendent issues\ Impact of conditions on reducing service standards\ inadequate infrastructure and tools for implementing policies.
	discordant content and resources	Implicit effects of educational content incompatible with religious and monotheistic view\ Lack of divine approach to educational resources.
	improper policies	Inefficiency of medical student admission processes\ Inappropriate student selection policies\ Non orientation of universities towards modern Islamic civilization\ Lack of a comprehensive program for religious competence development in medical education.
Contextual challenges	sociocultural conflicts	Insufficient basic competencies of the newcomer students as a result of inefficient public education\ Altered cultural values, conditions, and expectations of people\ Reluctance to religious, spiritual and moral issues in some parts of society\ Faded religious values such as altruism and self-sacrifice\ Non-compliance or failure to law enforcement\ Extremity or excessiveness (not moderation)\ inadequate attendance of families to religious competencies development\ Inefficient communication styles\ Influence of intergenerational gap on communication disruption\ Anti-religious propaganda in cyberspace.
	macro social structures	Complexity and time consuming nature of change\ Lack of proper policymaking\ Lack of serious intension for effective cultural change\ Non-transformational approach in health system structure and strategies\ Use of straightforward and simple solutions to complex issues rather than a comprehensive and multidimensional approach\ The unstable future prospect.

that is not meaningful, it will be trivial." Participant K

"The current attitude to religion by itself may be the main barrier. This is the secularity which prescribes to the doctor not to step out his medical tasks. That is to say: you go and medicate. Religion is none of your business.

Your duty is the people's body and religion has its own agent, dealing with fasting, praying, and other rituals. This I think is the most dangerous barrier." Participant I

2. Motivational challenges: Once a common understanding is achieved on the definition and components of religious competencies, any

practice in this field is subject to a kind of motivation, whether intrinsic or extrinsic. As the participants have pointed out, while an inner appeal and orientation, based on one's beliefs can be the best stimulus in this regard, external drivers posed by formal and informal organizations play an effective role in addressing religious issues in medical education and healthcare services.

"Unfortunately, as a result of propagandistic and superficial reference to religion, everybody feels to be full and overwhelmed in religious knowledge and no other education in this field is necessary. This is another barrier." Participant D

3. Methodological challenges: Medical education programs focusing mainly on providing learners with practical and clinical skills, has contributed to the development of diverse methods in teaching and testing of the competencies acquired in those fields. Nevertheless, more humane issues such as religious competencies require more appropriate methods not addressed properly yet. Lack of proper teaching and learning methodology and lack of evaluation mechanism for religious competencies have been mentioned by the participants in this study.

"Here, we are just giving information. The individual can sit at home and study them. We don't make space for the learner to present his ideas, his concerns, his religious questions and dilemmas. These are very important and involving the students in them is very important." Participant M

"Our evaluation criteria are not compatible with religion. In this way, no religious competency could be realized. In the curriculum itself, there is little room for religious training. As far as students are not evaluated on the basis of religious competencies, they do not find themselves obliged to move in that direction at all." Participant J. On the other hand, the negative consequences of such an evaluation should not be neglected. "To assign scores for cultural issues may lead to flattering and pretension" Participant E

4. Institutional challenges: Implementing any training program depends on requirements within the educational institution. Integration of medical education and healthcare providing systems in Iran provides opportunities and challenges in the institution. Thus, institutional challenges are considerably complicated, and though at the first glance, the shortcomings of the educational system appear to be the cause of the deficiencies in the health system; the interactions between the two require more attention.

"Most of the time, we are paying lip service. For decades, we claim that we are directing our education to these paths, but nothing happens. So, when there is no planning, there will be no achievement." (Participant J) Gaining religious competencies is time consuming. It is not possible to expect results in a year or two. Its infrastructure must be provided. Participant G

5. Contextual challenges: Any activity takes place within the cultural and social contexts and the macro structures in which it is situated. Sociocultural conflicts and macro social structures are the categories made up of the concepts noted by the participants.

"On the other hand, we must look at what we have received and what we deliver. Do we import heaven flowers and export hell firewood? That is not the case. Most of the times, our inputs are problematic. So we need to work harder." Participant G

"The staff have trouble getting their salaries, thus they do not perform their duties to the patient. These are the complexities of society. These are the different issues that are going on in our society." Participant X

"What we see, is not the matter of a day or two. Nor it is the product of direct education. To put forward an idea and deepen it in the minds of our youth, several films, several TV programs, mobile apps, even games, have been produced with the highest standards. Naturally, it is not an easy job to change this. This is the biggest obstacle." Participant E

Another obstacle is politicization. Even if you do the best, when the cabinet changes, everything is forgotten or abandoned. Our society is shortsighted. Every newcomer tends

to present the previous plans unworthy and substitute it with his own plan; a plan which could be wrapped up in his own term of responsibility. Participant D

Discussion

The present study identified the challenges confronted by the Iranian medical education system for the development of religious competencies in five areas of conceptual, motivational, methodological, institutional, and contextual challenges. Lack of clear understanding of any concept will hinder successful entry into it. Accordingly, the first challenge to be solved is the conceptual challenge, which has not received adequate consideration in Iranian medical education programs. In some countries, the recognition of religious and spiritual needs of the patients as a part of holistic care, has led to the inclusion of spiritual health topics in the medical schools curricula (21). Although, as a result of the lack of a full agreement on the concept and constituting parts of the religious and spiritual issues, there is not enough will and ability to establish and develop the religious and spiritual competencies (22).

While considering this as a major challenge to medical education, the historical background of Iranian medical science and profession demonstrates much attention to religious\ spiritual issues. Moreover, great emphasis has been put on these trends in Iranian upstream documents. Unfortunately, little has been done to realize and implement the documents. There is not a definite perspective of the relationship between religion and medicine, nor a rational and scholarly discourse on the use of religion in the field of health. These have led to some inappropriate approaches to the exploitation of religion that have disrupted people's trust and enthusiasm. In this way, inappropriate entrance not only does not lead in the richness of the field, but it may act as a threat.

Therefore, expression of religious issues in the field of medicine is sometimes met with opposition and resistance. The challenging relationship between religion and medicine requires thought and deep awareness of the

various obligations that shape medical practice decisions, policy, and professional behavior (23). Perhaps this lack of consensus in defining religious competencies has led to a lack of religious competence in all components of health, and documents on religious competencies are confined in the fields of psychology, counseling (22,24,25), or palliative medicine (26).

The second set of challenges could be regarded as motivational. In other words, beyond understanding the meaning and components of religious competencies, other factors are needed to encourage service providers to be involved. It seems that a combination of internal and external incentives is needed to consider paying attention to religious competencies as a facilitator of health promotion rather than just an additional burden. That is to say understanding the effectiveness of nonphysical components on health care could strengthen the internal motives. On the other hand, recognition of these components as a demand on behalf of the service recipients and formalizing it by the health care and medical education systems and formulating the mechanisms needed for them, could shape the external motives.

Diverse factors including increased number of patients with chronic or life-threatening diseases underscore the necessity of taking into account the spiritual aspects and avoiding the risk of non-humanized medical services (27). Teaching spirituality related material in medical schools in different countries (28), presence of chaplains and spiritual care teams in numerous medical centers (29), supporting physician-patient dialog on religious issues and respecting each other's values, inclusion of parameters related to religion, spirituality and beliefs in hospital accreditation guidelines (14), consideration of religious components in expected competencies of physicians (15), more and more attention to end of life rituals (30), and strengthened interaction between physician and patient with regard to issues like religiosity, spirituality, praying, and religious\ spiritual conversation (31) are evidences of developing external motives. This is a crucial step, since motivation leads to contribution,

and contribution leads to a sense of belonging, and ensure the continuity and durability of the activity.

The third category embraces the methodological challenges. This means that as a result of the predominance of the biomedical paradigm as the basis of medical science and profession, the medical education system prevents the flourishing of religious paradigm to form and strengthen a holistic view. The reduced physicalistic view at medicine, which began in the early twentieth century following the publication of Flexner's report on American and Canadian medical schools, led to disastrous consequences by neglecting spirituality and health relationship and ignoring the role of humanistic and spiritual elements in patient care (32). Focus on the specialization and lack of effective inter professional communication has led to ignoring human integrity and his extensive needs, which in turn, hinders accurate and timely diagnosis of patients' needs. The following maltreatment leads to more complicated conditions, dispersed, sectional and temporary care, widespread medical errors, contradictory and parallel treatments, as well as health service delivery according to specialties rather than client-based services with regard to their actual needs (33).

In the meantime, technological advances in the fields of diagnosis and treatment, in spite of their vital role in health promotion, led to bypassing more humane elements and reducing it from a holistic and service oriented model to a technology oriented one (28). However, due to the inefficiency of the medical education focused on clinical education and isolated from other domains, there has been a shift in the orientation of medical education tending to incorporate topics such as literature, religion and philosophy (34). Such a tendency is emerging in the Iranian medical education, but needs to be accelerated for desirable ends.

The fourth category of challenges lies within the medical education system and educational institutions. The education system willing to have developed religious competencies in graduates as its output, the provision of

religious competency-based health service as its outcome, and the promotion of holistic human health as its impact, requires to undergo essential reforms in its inputs and processes. Undoubtedly, a main portion of what impedes the optimal realization of expected religious competencies in medical students, originates from within the system, being detectable in its different parts and characteristics. In spite of the fact that many health care systems throughout the world are getting more and more alert to the benefits of religious\ spiritual interventions on the optimal progress of health processes, inadequate knowledge and experience to enter this field of service and the incompetency of most of the medical graduates are the major barriers to its realization. In other words, addressing nonphysical aspects of human beings by health care professionals requires capabilities that currently are overlooked by medical schools as a result of their dissociation from religious and spiritual issues (35).

An active approach to religious competency education, involves implementing a multilevel curriculum with special attention to hidden curriculum through integrating it in different stages of medical education to produce more lasting outcomes (36). Thus, trivial actions, such as offering a course, have limited effectiveness. Miller, therefore, proposes integrating cultural education into all building blocks of clinical education to the extent that cultural sensitivity becomes an integral part of any professional practice (37). The limited success of direct educational interventions to optimally influence on behaviors has led to other approaches to be focused on for developing the virtues and personality traits required for physician performance, while preventing burnout or reduced empathy (38).

In general, the introduction of topics such as religion and the integrated approach to medicine is changing the face of today's medicine (39), and Iranian medical education should inevitably be directed in this direction. Religious competencies though not addressed independently in the Iranian medical education curriculum so far, they are sporadically mentioned in the 2015 document of the

expected capabilities of medical graduates in Iran, especially in the context of professional commitment, ethics, and medical law, which can act as the baseline for this movement.

Finally, the fifth set of challenges to the development of religious competences was identified as contextual challenges, mainly associated with the overall space throughout society in which these competencies are to be realized. Briefly, a main part of barriers of developing religious competencies in medical education are rooted outside the field of medical education and the interconnections of these different systems. Any higher education system is regarded as a subsystem within the ecological system, and must inevitably interact with other subsystems to ensure its existence and growth. However, higher education systems are expected to be influential, amending and correcting the shortcomings and faults of other systems (40) through guiding and being initiative. Thus, institutionalizing moral and human values and promotion of indicators in the field of holistic health are expected from medical schools and universities. It seems that the upstream documents have been formulated with such a view that their implementation can lead to significant steps towards these goals.

As a limitation to this study, the participants' diverse conceptions of religious competencies were noteworthy. This was resolved in those familiar with the concept of competency in the field of management. On the other hand, religion and spirituality are two overlapping concepts, used interchangeably most of the times, and treated the same in parts of this study. Another limitation is the qualitative research method which lacks generalizability.

Conclusion

Although religious and spiritual competencies have received great attention in different medical education programs in the world, the development of religious competencies in the Iranian medical education is in need of particular attention. This is possible when the medical education systems can overcome the challenges on this path, or apply proper approaches to eliminate their

effects on its outputs. Clarifying the concept of religious competencies and efforts to confirm the holistic view, strengthening internal and external motives, developing appropriate methodology, especially with an interdisciplinary and trans-disciplinary perspective, as well as transformation of the medical education system are the most important measures to be taken. Furthermore, it should be borne in mind that higher education institutes, despite being influenced by other systems and subsystems, must exhibit their pioneer role on the social movement towards transformation, evolution, and growth.

Conflict of interest

The authors declare no conflict of interest.

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