Journal of Religion and Health (2019) 58:246–258
https://doi.org/10.1007/s10943-018-0714-z

ORIGINAL PAPER

Medical Students' (Dis)comfort with Assessing Religious and Spiritual Needs in a Standardized Patient Encounter

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Published online: 10 October 2018

Abstract
Most patients want to discuss their religious and spiritual concerns, yet few physicians discuss it. First-year medical students (n = 92) interviewed a standardized patient experiencing spiritual distress. There was a significant difference among the students' reasoning for their (dis)comfort and (mis)matching religion with their patient (X^2 = 21.0831, $p < .05$). Most students whose religion matched their patient felt comfortable because of having this in common with their patient. Most students whose religion did not match that of their patient ascribed their comfort to their religious belief to be open and accepting. Discomfort may stem from more individual factors than a (mis)match in religion, as most of the students reported feeling comfortable.

Keywords Spiritual concern · Religious diversity · Standardized patient · Medical education

Introduction

Most patients want to discuss their religious and spiritual concerns with their physicians, and integrating religious and spiritual needs in healthcare improves health outcomes (Balboni and Peteet 2017; Cohen et al. 2016; Ehman et al. 1999; Jim et al. 2015; Koenig et al. 2012; Li et al. 2016). Even though most patients want to discuss their religious and spiritual concerns with their physicians, few physicians discuss it (Ernecoff et al. 2015).

One explanation for the lack of dialogue is discomfort with the topic, as evidenced by the practice of topic avoidance by physicians (Villagran et al. 2017). After initially learning to use the FICA interview to assess religious and spiritual needs, medical students used this assessment with rates of 90%. One year later, rates dropped to 63%, with some medical

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students indicating that they did not do the FICA interview because they were uncomfortable with the topic (Borneman et al. 2010; Puchalski and Romer 2000; Schmidt et al. 2017).

In this study, we consider the question of whether the religiosity or spirituality of the physician impacts comfort during a conversation about a patient's religious and spiritual needs. Does a perceived difference of religion affect the level of comfort? When the doctor is Jewish and the patient is Catholic, would the doctor be uncomfortable during the encounter due to this perceived difference? Or, will he/she be comfortable when the patient is also Jewish, if he/she perceives this as a match in religion?

This perception of a match in religion between two individuals can be thought of in terms of a shared reality. Echterhoff et al. (2009) describe four definitions of the word "shared." Firstly, shared means "communicated or disclosed to others," a meaning that references the sender of information but not the recipient. A second definition of shared is "divided up into portions" (Echterhoff et al. 2009). This definition acknowledges that each holds a different segment of the reality and that although they may not seem to match directly, altogether they provide the complete story. In this sense, shared is collaborative. The third definition of shared is "partaking in a consensus," as in sharing a view or opinion (Echterhoff et al. 2009). This definition is the most objective description of shared, as direct observation would allow for registering this sameness.

The fourth definition of shared may be the most applicable, "held and experienced in common" (Echterhoff et al. 2009). This definition would encompass the experience of commonality and matching of the inner states, which may go beyond the actual religion to include a wider experience. This is the definition we used for this study, as it seemed to best reflect the multifaceted nature of perceiving a match and the philosophical breadth of the concept of matching religion.

Our study is primarily a qualitative exploration into the question of whether perceiving a match in religion affects medical students' comfort with discussing their patient's religious and spiritual needs. Broadly, first-year medical students interviewed a patient experiencing spiritual distress. Students reported whether they perceived a match, rated their (dis)comfort with the patient interview, and responded to reflective writing questions. In this interview, students explored the patient's social history through using patient-centered skills to enhance the therapeutic relationship, understand the patient's perspective, demonstrate empathy for their emotional impact of the discussion, and share the task of increasing health and collaborative planning (Bensing 2000; Mead et al. 2002; Silverman et al. 2005; Zandbelt et al. 2007). Student learners in this study had participated previously in three exercises and simulations teaching patient-centered skills, and their task here was to use these skills in the context of conducting an advanced social history patient interview.

We explored the following hypothesis: When medical students' religion matches their patient's religion, students will report feeling comfortable with discussing their patient's religious and spiritual needs; when students' religion does not match their patients' religion, or when students report they do not have a religion, they will report feeling uncomfortable.

Methods

Curriculum

First-year medical students met with a standardized patient (SP) to gather a social history in an Advanced Social History workshop. SP simulation is used in medical education to offer the students practice or assess clinical skills in the areas of interviewing, physical examination, critical thinking, and procedural skills. SPs are trained patient actors that act and react as real patients, but scripted. These individuals act and react within the objectives of the assignment and provide the students with real-life-like experiences. The term standardized derives from the controlled nature of these patient encounters. As the SPs assess the students' clinical skills, their performance and assessment should be reliable, valid, and standardized in order to exhibit a fair illustration of the students' abilities and skills (Barrows 1993). During the orientation to the workshop, a faculty member instructed the students to look for a unique story from the patient, acknowledging that certain areas may need more emphasis based on the patient's particular needs, rather than approaching the interview in a checklist fashion. After the orientation, students met individually with their SPs, responded individually to written questions, and then met with another faculty member for a group debriefing discussion. The format for this curriculum teaching the rationale for including a discussion of patients' religious and spiritual needs was designed in a 1:1 model and reported for use with groups (Ledford et al. 2014; Schmidt et al. 2017).

The patient was a Catholic middle-aged female presenting to the doctor with a cough. Although she had a cross-tattooed on her arm, she did not state her religious identity unless the student followed through with this aspect of the Social History or in any other way inquired for more information about her religion or spirituality. Two minutes into the interview, she expressed feeling deserted by God who had not responded positively to prayers for healing her elderly mother. Ten SPs were trained for this case, and the prompt was delivered standardly within the first few minutes of the interview. In order to build authenticity, the SPs were trained to not outright state their religious identity unless the medical students opened this area for discussion. If the student pursued this story further, the patient offered more information about her spiritual distress.

Design

We decided to include qualitative questions because of the sparse literature available describing the relationship between perceiving a match in religion and how that relates to comfort with discussing patients' religious and spiritual needs. For triangulation of methods, we used a nested design that also included two objective questions (Miller and Crabtree 1994).

After concluding their patient interview, the students engaged in individual reflective writing with the following questions:

1. How do your own personal beliefs/religion/spirituality impact your ability to talk with your patient about his or her religion/spirituality?
2. If you did not address religion/spirituality in any way with your patient, why not?
3. How would you describe your religion/spirituality?
4. Why do you think you felt comfortable/uncomfortable/neutral with conducting a religious/spiritual assessment?

5. If your religion matched that of your patient, how did that impact your level of comfort with doing FICA or in another way addressing religious concerns?
6. If your religion did not match that of your patient, how did that impact your level of comfort with doing FICA or in another way addressing religious concerns?

They also completed a 5-point Likert scale (extremely uncomfortable, uncomfortable, neutral, comfortable, and extremely comfortable) for a single-item question about their comfort with the religious and spiritual component of their patient's story: "If you did the FICA (interview asking about Faith, Importance of faith, religious Community, and how to Address their religious needs in healthcare) or in another way addressed the patient's religious concerns, how comfortable were you with doing this?" (Borneman et al. 2010; Puchalski and Romer 2000). To inquire whether there was a match in religion, instead of defining this a priori, we used a phenomenological approach of allowing students to determine for themselves whether or not they perceived a match in religion between themselves and their patient. Students selected a single response to the question, "If you have a religion, did you identify as being from the same religion as the SP":

1. Yes, we were from the same religion.
2. No, we were not from the same religion.
3. I don't have a religion.
4. I'm spiritual but not religious.

Informed Consent and Debriefing

These questions come from a larger data set approved by the IRB at American University of the Caribbean School of Medicine. The study design mirrored that of a key study by Ledford et al. (2014). Their study employed a sensitizing experience design using the element of surprise to heighten the affective response in students during a simulation experience, thereby making the experience both more engaging and more memorable. The sensitizing experience design necessitates using implied consent because if students know aspects of the case before meeting their standardized patients, then there would no longer be a heightened affective component to their simulation experience. All students enrolled in the first-year clinical skills course were required to engage in this simulation. During their small group orientation, one of the faculty researchers explained to them that they would have an opportunity to reflect on their simulation afterward and that it was their choice whether they would like to write down their thoughts or not; to anonymously turn in their written responses; to turn in a blank sheet of paper; or to retain their written responses for themselves. During this reflection time there were no faculty members present to observe and know who had chosen to turn in or to keep their reflections, preventing any possible harm for this decision to participate or decline participation. A cardboard box was available for those students who chose to turn in their written responses. Students then moved to a small group debriefing discussion led by another faculty member. In this debriefing, they learned about the discrepancy between patients' wanting to discuss their religious and spiritual needs with their physicians and their physicians' reluctance to do so; the benefits and rationale of employing a sensitizing experience in medical education; and contact information to discuss any aspect of the study or their participation in it. They also discussed their thoughts and feelings about their simulation experience and study participation.

Sample

Of 110 first-year medical students, 100% completed the workshop and 100% turned in their anonymous written reflections. All students completed some reflection questions, and most students completed most or all of the questions. For the qualitative analysis, we looked at the students' reflections as one response per student instead of looking at the responses per question, so we did not need to drop any students for omitting a single individual question. We dropped 17 students from the data set who were confused about the instructions for the simulation. Instead of conducting a social history with their patients, these 17 students had discussed the history of the presenting problem or else discussed a portion of the social history but never discussed religion or spirituality with their patient (Schmidt et al. 2017). Although it is possible that these 17 students may have omitted this assessment due to their discomfort, our questions concerned their comfort or discomfort during the assessment. Therefore, our sample only includes those students who, to any extent, discussed religion and/or spirituality with their patient. We dropped one additional student from the study whom we could not categorize due to insufficient information (i.e., student rated feeling neutral regarding comfort with discussing religion, did not respond to the question about match, and only wrote "not important" on the written reflection section). We discussed the option of categorizing this student with the (dis)-comfort group, but agreed there was not enough clarifying written reflection to contradict the student's Likert response of neutral regarding comfort. With these 18 students removed from the data set, the final sample size was 92.

Qualitative Coding

We approached the qualitative analysis from a critical realistic ontology, maintaining the belief that we are imperfect at perceiving reality, so we must be critical of our perceptions. We acknowledged our bias toward the data that when students' religion matched that of their patient's they might feel more comfortable discussing their patient's religious and spiritual needs. CS and LN coded the written reflections, and we discussed the possible impact of our own religious beliefs (theist and atheist) and backgrounds (both protestant by history and one currently practicing) on our coding decisions. To check for possible influence from this bias, hopefully enhancing trustworthiness in our analysis, we discussed each step of this analysis during weekly research team meetings. We looked for and examined negative/deviant cases to enrich our perspectives on the data (Elder and Miller 1995). We based our analytic approach on content theory.

We developed codes to characterize students' narrative perceptions of whether their own religion matched that of their patient. Some examples of codes include "match, I'm Catholic," "match, I'm Christian," "not from the same religion," "I'm atheist," and "I'm spiritual but not religious." Authors CS and LN independently coded all responses. Then, we discussed our coding decisions and resolved our only disagreement in coding with a coin toss. Applying the phenomenological approach, we decided to honor the students' decisive statement about matching religion, even when students stated they were "Christian" or "Methodist" and not Catholic like the patient, acknowledging that the perception of a shared commonality is more important than the concrete "sameness." In sum, we learned from their reflections that we needed to acknowledge and set aside any preconceived notions of what we thought it meant to match religion, thereby using their indications of whether or not they matched, not our opinions.

We developed a different set of codes to classify students' descriptions of how they felt discussing religion and spirituality with their patients. We identified eight codes with the following examples:

1. Open, accepting, non-judgmental, eager to learn: "Being Hindu we are taught to be very open minded. I feel as if this quality helped me listen to my patient with no judgments and let the patient tell me more about herself."
2. Comfortable: "It doesn't bother me at all. I am comfortable speaking with people of all religions."
3. My beliefs don't impact the patient encounter: "My religion spiritual belief has no impact on bringing up the topic of religion or talking about it."
4. Previous exposure to religious beliefs or my knowledge about religious beliefs increased my comfort: "I was raised religious but have recently not been very active in my religion. I feel like my religious background and current feelings give me some understanding of both religious and not very religious people."
5. It's about the patient, not about me: "I think I felt comfortable because I am here to help my patient in any way that I can. If that means understanding how their religion impacts their life, then I am more than willing to speak to them about it."
6. I am religious/spiritual: "We were both practicing the same religion so it was easy to talk about it openly."
7. I was uncomfortable: "It is difficult for me to relate on any level with someone who is religious. Frankly, I am not very religious and it is something I do not like talking about."
8. My patient was comfortable. "I felt comfortable because the conversation was natural and not forced and the patient seemed comfortable with the conversation as well."

In order to promote reflexivity, during weekly team meetings, we openly discussed our own reactions to reading the students' responses. We then collapsed some of the eight initial codes to create five, and then four, categories regarding the students' reasons for (dis)comfort with discussing religion and spirituality. Below are example quotations for each of the final four categories of reasons for (dis)comfort, with manual calculations of inter-rater reliability (www.statisticshowto.com/cohens-kappa-statistic/). See Table 1.

I am open and accepting (Cohen's Kappa = .46, Moderate Agreement)

- "I feel my lack of spirituality frees me to be curious and nonjudgmental with a variety of religious practices and beliefs."
- "Being Hindu we are taught to be very open minded. I feel as if this quality helped me listen to my patient with no judgments and let the patient tell me more about herself."
- "I think not having a religion made me curious about hers."

Table 1 Second and third round of qualitative coding—reasons for (dis)comfort

1.	Have a common background with their patients	30% (n = 33)
2.	Felt comfortable, open, accepting, non-judgmental, eager to learn	26% (n = 29)
3.	My personal beliefs are irrelevant. If it's important to my patient, it's important to me	25% (n = 28)
4.	Discomfort/disengaged	18% (n = 20)
	Uncomfortable (n = 11)	
	Religion is irrelevant to medical care (n = 9)	

About my patient, not about me (Cohen's Kappa = .39, Fair Agreement)

- "I wanted it to be about the patient, not me. I offered help without elaborating or providing my own personal beliefs."
- "Each individual has their own story, and my role is to hear that story without any bias or preconceptions."
- "I think I felt comfortable because I am here to help my patient in any way that I can. If that means understanding how their religion impacts their life then I am more than willing to speak to them about it."
- "I was comfortable because I could tell that the SP was honestly in touch with her spirituality and this helped to build a mutual respect relationship."

We have something in common (Cohen's Kappa = .55, Moderate Agreement)

- "I felt like I was able to relate, since I also have felt somewhat abandoned by God at times."
- "I have grown up my entire life in a religious family and feel very comfortable speaking with other people about it."
- "I felt comfortable because I have felt lost, found, lost found, etc. We are all experiencing the human condition and want to be loved."

I'm uncomfortable/it's not important (Cohen's Kappa = .42, Moderate Agreement)

- "Just have no background and I don't want to insult a patient. Religious beliefs can be strong and tempers can run hot."
- "I just don't find it pertinent in treating a patient. My treatment is not dependent on people's personal beliefs."
- "To me religion is the hardest topic to talk about. Even though I am religious that doesn't help me when addressing this topic."
- "It is difficult for me to relate on any level with someone who is religious. Frankly, I am not very religious and it is something I do not like talking about."

Analysis

In order to consider the question of whether experiencing a match in religion with their patients impacted their comfort with discussing the patient's religious and spiritual issue, we created a Chi-square table. Some students wrote in their reflection questions about feeling very uncomfortable, yet rated feeling very comfortable, and the converse. Similarly, some students rated that their religion matched that of their patients, yet their reflections indicated they did not match. Because of this seeming contradictory information, we decided to qualitatively classify each student as comfortable or uncomfortable by looking at their Likert rating about (dis)comfort and comparing that with all of their reflective writing that related to (dis)comfort. We used the same process to determine whether or not students perceived a match between their religion and that of their patient. We approached this process with the same phenomenological approach to respect, in any way they chose to understand and define their comfort and match by looking collectively at their rating and their set of written reflections.

Two raters completed this process, individually, before meeting to discuss the coding. We manually calculated Cohen's Kappa for inter-rater reliability (www.statisticshowto.com/cohens-kappa-statistic/). We disagreed on the categorization of comfort in 7 instances

(Kappa = .72, Substantial Agreement) and match in 1 instance (Kappa = .97, Near Perfect Agreement). See Table 2.

Creating the Chi-square table required resolving our eight instances of inter-rater disagreement. We used a coin toss to resolve the disagreements, and this produced heads four times and tails four times. We grouped these categories in a Chi-square table in order to look at whether students from the same religion as their patients were comfortable due to that shared background. For the Chi-square analyses, we used the Chi-square calculator at www.Socscistatistics.com.

Results

Contrary to our initial hypothesis, there was not a significant difference in feeling comfortable or uncomfortable based on whether or not the students felt a match in religion with their patient. A 2 × 2 Chi-square analysis was not significant (X^2 = .4697, n.s.), using the categories of comfortable/uncomfortable and match/no match. See Table 3.

There was a significant difference; however, when students were grouped more specifically, according to their reasons for feeling (un)comfortable using the four thematic groups identified in the qualitative analysis: (1) I have something in common with my patient, (2) I am open and accepting with all religions, (3) It's about my patient, not about me, and (4) I feel uncomfortable talking about religion. We analyzed these subsets of (dis)comfort by the subsets in religious match students perceived between themselves and their patients, (1) "Yes, we were from the same religion," (2) "No, we were not from the same religion," (3) "I don't have a religion" or (4) "I'm spiritual but not religious." This 4 × 4 Chi-square was significant (X^2 = 21.0831*, $p < .05$). See Table 4.

Matched Religion and Felt Comfortable Due to the Commonality

This more complex (e.g., looking at reasons for feeling comfortable rather than whether or not there was comfort) look at the relationship between matching religion and comfort discussing religious and spiritual needs supports our hypothesis. Thirty percent (n = 28) of students indicated that their religion matched their patient's religion; 46.4% (n = 13) of these matching students explained that they felt comfortable with discussing religion

Table 2 Inter-rater reliability in qualitative analysis

		Match (Kappa = .97)	
		Student's religion matched their patient's religion	Student's religion did not match their patient's religion
Comfort (Kappa = .72)	Uncomfortable		
	Raters agreed	2	11
	Raters disagreed	2	2
	Comfortable		
	Raters agreed	23	48
	Raters disagreed	1	3

Table 3 2 × 2 Chi-square, (mis)match × (dis)comfort

	Student's religion matched their patient's religion	Student's religion did not match their patient's religion	Total
Uncomfortable	4	13	17
Comfortable	24	51	75
Total	28	64	92

X^2 = .4697, n.s.

Table 4 4 × 4 Chi-square, type of (mis)match × type of (dis)comfort

	"We have something in common" (Kappa = .55)	"I am open and accepting with all religions" (Kappa = .46)	"It's about my patient not about me" (Kappa = .39)	"I feel uncomfortable" (Kappa = .42)	Total
Match (Kappa = .97)	**13**	6	5	4	28
Different religion (Kappa = 1.0)	3	**15**	9	5	32
No religion/ atheist (Kappa = 1.0)	1	5	6	6	18
Spiritual but not religious (Kappa = .97)	3	3	6	2	14
Total	20	29	26	17	92

Bold values indicate the highest difference

X^2 = 21.0831, $p < .05$

because it was "familiar" and they "had something in common" with their patient. Eighteen percent (17.8%, n = 5) of the matching students indicated they matched religion with their SP, even though they were not currently religious but had grown up in that religion and attributed that their familiarity led to their comfort.

(Mis)matched Religion and Felt Comfortable Due to Their Openness

Many students whose religion did not match that of their patient were nonetheless comfortable discussing their patient's religious and spiritual needs. Of the 69.6% (n = 64) students whose religion did not match that of their patient (either different religion, not religious, or spiritual but not religious), 35.9% (n = 23) explained their comfort as due to their "openness and acceptance" of religions, in general. Among the 34.8% (n = 32) students who did not match because of a mismatch in religion, 46.9% (n = 15) explained that they felt comfortable because their religion taught them to be open and accepting of all religions. Students who did not match because they identified as not having a religion or as being spiritual but not religious had more varied explanations for their comfort. See Table 4.

Not Religious

Students who described themselves as not having a religion or as being atheist (19.6%) endorsed being open and accepting, focusing on their patients rather than themselves, and feeling uncomfortable at relatively equal rates. They were less likely to state that having something in common with their patient explained their feelings of comfort. Students who described themselves as spiritual but not religious (15.2%) showed a similar pattern to their explanations of their (dis)comfort. See Table 4.

Uncomfortable

Nineteen percent (18.5%, $n = 17$) of students reported discomfort with discussing their patient's religious needs. Forty-one percent (41.2%, $n = 7$) of these uncomfortable students reported not having a religion themselves. Twenty-three percent (23.5%, $n = 4$) of the uncomfortable students matched religion with their patient, and one of these students indicated that their discomfort stemmed from hearing their patient question her relationship with God (Table 4). Notably, Schmidt et al. (2017) reported that in the group of students who had not assessed for religious and spiritual beliefs (e.g., whom we dropped from the current study), only one student reported feeling uncomfortable, whereas the other students reported feeling neutral to extremely comfortable.

Discussion

Our results provided partial support for the hypothesis that being from the same religion would help medical students feel more comfortable discussing their patient's religious and spiritual needs. Almost half of the students who found this match in the same religion felt more comfortable because of the familiarity in having a matching religion. Other students, however, provided different explanations, and some were uncomfortable. One student explained that hearing their patient talk about having lost her faith was quite uncomfortable. Another student reflected, "Even if we were of the same religion, that does not mean we believe the same things the same ways or feel the same about it."

Contradictory to our initial hypothesis, most students from a different religion (i.e., a mismatch) were comfortable with the assessment. They provided reasons such as "Being Hindu, we are taught to be very open minded. I feel as this quality helped me listen to my patient with no judgements and let the patient tell me more about herself" and "Sikh—very open to engaging about religious discussion with patients."

Similarly, most students who reported having no religion or who were spiritual but not religious also rated themselves as feeling comfortable. One student wrote, "Not having a religion made me curious about hers." Their reasons for feeling comfortable were more varied than reasons from the students who matched religion with their patients or the students mismatched from a different religion.

In sum, these responses suggest we should not hold assumptions about students' comfort with the assessment of religion based on their own religious affiliation, nor should we assume that students will feel more comfortable when they see patients with a matching religious background than when there is a mismatch. Future studies could explore these scenarios in greater detail.

Training directors may be able to use findings from this study to help increase their students' comfort with assessing religious and spiritual needs by facilitating a conversation

about the topic, without assuming (dis)comfort when there is a (mis)match between religious beliefs. In addition to this, a possible application from this study could be for a broad range of healthcare providers; in essence, regardless of their own religious background, they may feel comfortable with discussing and assessing the diverse religious and spiritual needs of their patients.

Limitations and Recommendations

Perception of a match in religion is both highly complex and highly subjective, requiring both the ability to identify someone else's religion and then to appraise it in the context of one's own religion to determine whether or not there is a match. Identifying someone else's religion begins with perception. Perception may shape our knowledge, but our knowledge may drive our perception (Tacca 2011). Having a general knowledge of religious symbols, clothing, and references may help the learners' perception of the patient's religious background and possible struggles in this area. Knowledge about the potential impact religion can have in someone's life based on information from academic reading and lectures may result in a recognition of the patient's religion and possibly add to their level of comfort. With our finding of the highly individualized notion of a match, there are possibly other factors involved, which could be explored in future research. It would also be good to look directly at the extent to which students recognized a religious identity (correctly or incorrectly) in their patient, as well as the extent to which they have formulated their own religious identity.

Knowing someone else's religious identity opens the door to considering the presence of a match. For some, this appraisal may occur objectively, as in Catholic versus not Catholic. For others, this appraisal may involve looking more deeply to compare and find commonalities, as in deciding we are both highly religious and spiritual, though from different traditions, so we have this in common. The process of sifting through information to find commonalities, and to rank and even negate differences deemed not aligned, is highly complex and would benefit from a more in-depth analysis than we conducted (Markman and Gentner 1996).

After a careful review of the wide spectrum of concepts involved in the perception of commonalities, we found we may have asked the wrong question in this study. The perception of a match in religion may be a question that is too simplified. Being from the same religion may be seen as the concrete answer to whether there was a match. The recognition of the role religion can play in someone's life in general, however, may be perceived as similar or as a commonality and therefore a match. In our study, many students recognized there was no concrete match of religion (as the question was phrased), but they felt very comfortable due to the recognition of the important role religion plays in the patient's life (as they explained in their written reflection). Even though objectively they did not appear to match, there was a perceived similarity through a shared reality that led these students to the conclusion they matched religion with their patient.

Another factor that may have affected the perception of a match may be the level of depth in the conversation that has taken place in the encounter with the patient. Assessing the patient's religious background superficially may influence the perception of a commonality. The level of depth that is applied during the interview highly depended on the students' ability to use patient-centered skills in a genuine fashion; truly wanting to find out more about the patient's perspective may result in a deeper connection which could heighten the sense of a shared reality or "a match." Many students may still not understand

the level of depth that is needed, just checking discussion items of a checklist mentally once it is superficially discussed or merely mentioned (Schmidt et al. 2017). Future studies could include a measure of depth or thoroughness to the conversation about religious and spiritual needs.

Additionally, there may have been a varied level of consideration for the necessity to reflect on one's religion. Some students, and perhaps even some healthcare providers, may hold the idea that the professional role of a healthcare provider requires a need for distance to allow for a sole emphasis on the patient, not the personal beliefs of the physician. The extent to which the student valued or found the topic important could also have influenced their decision of whether or not there was a match.

The level of comfort could also derive from other visual and audible stimuli that affect perceptions, knowledge, and experiences. We asked the students whether the match impacted their comfort, but they may have been subconsciously influenced by the warmth of a smile from the patient or another possible nonverbal stimulus that had not been staged, but just takes place. Also, the gender, race, and age of the patient could have influenced the perception of a match in the form of implicit bias (Hall et al. 2015).

A known limitation to any study that involves simulation is the varying ability from the learners to suspend disbelief in the SP scenario or encounter, even though a formal fiction contract has been signed by the learner (Tun et al. 2015). We worked under the premise that the learners believed enough in the staged reality to safely practice their skills. Individual variability in this process can affect the accuracy and thoughtfulness of the reflection answers and the learners' performance during the encounter.

The question as to why physicians and medical students tend not to ask their patients about their religion remains. Our study focused on the presence of (dis)comfort in the context of a (mis)match. Other reasons for omission of discussing their patient's spiritual and religious needs assessment need to be explored, such as professional fatigue, lack of time, or the perception of low importance of the topic. Future studies could look at some of these other factors.

Acknowledgements The authors would like to thank the Clinical Skills Simulation Center at the American University of the Caribbean School of Medicine for their assistance with delivering this curriculum: Alyssa van den Bosch, Fallon Peterson, and all of the standardized patients. Teresa Boese, DNP, provided substantive commentary in her review of this manuscript. IRB: The American University of the Caribbean School of Medicine IRB approved the study as exempt from human subjects review due to the use of routine evaluation data for study # 2015-005 on November 12, 2015. The IRB waived written informed consent due to the sensitizing experience curriculum design along with the research procedure used permitting students to refrain from providing their responses to the researchers, the anonymity of their responses, and the absence of observers to note their decision to provide or withhold their responses.

Compliance with Ethical Standards

Conflict of interest The authors report no conflict of interest.

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