Journal for the Study of the Religions of Africa and its Diaspora 6.1 (November 2023): 76-89

Religion and Spirituality in Health and Medical Education: Batswana Medical Practitioners' Views

Tinoonga Shanduka

Abstract

This paper discusses Batswana medical practitioners' views on the impact of religion and spirituality on health and medical education. The paper relies on the fieldwork research findings on the impact of beliefs on health seeking and health provision behaviors in Botswana. Additionally, the paper is a product of internationally published literature sources on the importance of religion and spirituality in healthcare provision. In terms of methodology, the paper used a variety of data sources. Primary data was collected through fieldwork using questionnaire and interview guides as instruments for collecting data. Secondly, a desktop approach was used for collecting secondary data. Documentary analysis and review of varied literature sources also produced data for this paper. The paper established that religion and spirituality are essential aspects of patients' life which ought to be addressed by medical practitioners during healthcare provision in Botswana. These are part of alternative medicine important for holistic healing of illness. The study found out that spirituality and religion should be part of medical education in Botswana.

KEY WORDS: Bible, Health, Medical Education, Religion, Spirituality, Theosomatic Medicine

Introduction

> Nothing in life is more wonderful than faith — the one great moving force which we can neither weigh in the balance nor test in the crucible . . . Faith has always been an essential factor in the practice of medicine . . . Not a psychologist but an ordinary clinical physician concerned in making strong the weak in mind and body, the whole subject is of interest to me (William Osler. In R. D'Souza, 2007).

The relationship between humanities and sciences has always been a challenge among scholars. Humanities and natural scientific disciplines are viewed as two sides in opposition. Humanities are less scientific but warm hearted while natural sciences are considered as cold and without feelings. Though faith or religion, a discipline within humanities is different from natural sciences such as modern medicine, D'Souza (2007) cited above observes that there is a link between them. This paper assesses the link between

humanities (religion and spirituality) and hard science (health and medicine) by examining Botswana medical doctors and nurses' views on the role of religion and spirituality in human health. Levin (2001) holds that despite some arguments which seek to prove that there is no link between spirituality and religion on one side and medicine on the other side; there is research evidence which indicates that these two different fields have a point of intersection.

This paper examines the impact of beliefs on health seeking and health provision behaviours in Botswana. The paper starts by presenting findings on the impact of religion and spirituality on health according to Batswana medical practitioners. This is followed by a general discussion on Batswana medical practitioners' views on the importance of religion and spirituality on human health. It then outlines the benefits of integrating religion and spirituality in healthcare systems. Moreover, the challenges that hinder the incorporation of religious and spiritual aspects in healthcare provision systems are discussed. The paper then addresses issues of religion and spirituality in medical schools. Finally, the paper provides a conclusion.

Impact of Religion and Spirituality on Health- Botswana Medical Practitioners' Views

This section presents the findings of a fieldwork study on the impact of beliefs on health seeking and health provision behaviors in Botswana. Data was obtainable from modern medical practitioners (nurses and doctors) who were recruited from hospitals and clinics, in different parts of Botswana. Regarding the relationship between faith and health, medical practitioners were of the view that faith motivates medication adherence; spiritually helps with the healing process; influences good behavior and health. Batswana medical practitioners believed that faith and healing are connected to some spiritual forces. Moreover, they were of the view that psychologically, patients should have faith so that medical drugs can cure their sickness. Additionally, they said patients with faith were motivated to take the drugs.

During the study, medical practitioners were asked about where they placed God in human illness. In response, they acknowledged the power of God in health and healing. Moreover, they recognised patients' religious beliefs yet sticking to medical diagnosis and treatment. Furthermore, Batswana medical practitioners described the Bible as a blueprint for healthy living. One medical practitioner responded as follows, "I believe God is above everything, even when I am personally experiencing some social problems in my life, when I come to the hospital I ask for his strength and wisdom to help his people with diligence. I place God above, but I encourage patients to take treatment fully while also praying to God for healing" (Interview, GAMP002).

Regarding the cause of illness, medical practitioners adopted a neutral position in relation to wrath from God, lack of protection from God, the devil and evil spirits and curse of God as possible factors that can cause illness. Nonetheless, they cited physical factors (bacteria and viruses), stress and behavioural factors (bad life-style) as the main causes of illness.

One of the areas that required medical practitioners' answers was on training on religion and health in medical schools. The majority stated that it was important for medical schools in Botswana to offer courses on health and religion/spirituality. Nearly all the

medical practitioners stated that their training included very little to nothing on religion and health. Medical doctors' responses in questionnaires showed that their training had reasonable content (ranging between limited and comprehensive) on the effects of religion and belief systems on health care and respectable patient care. They stated that the curriculum at medical schools where they received training had limited content on traditional health, faith healing and spirituality.

Nurses who were interviewed stated that they learnt something on religion and health from sociology courses while medical doctors learnt a little from courses on Community Health/Medicine. Be that as it may, medical practitioners were taught to accept patients with their beliefs, treating all of them equally knowing that they have different beliefs. It was important for medical practitioners to be taught about people's belief systems if they are to help patients better. Responding to a questionnaire, the majority of medical practitioners (69%) believed that all of them should have training in using alternative medicine in heath provision. This means they supported the inclusion of religion and spirituality in medical practice. Some further argued that it is important for medical practitioners to have a working knowledge of other religions besides Christianity because other health seekers in Botswana believe in religions such as Islam, Hinduism and so on. Having basic knowledge of these religions would help medical practitioners to address their health effectively. However, there were some few practitioners who were not certain regarding the relevance of religion in health.

Discussion

The review of literature on the impact on religion and spirituality on health and medical education is also informed by the findings of the fieldwork research in Botswana titled "The impact of religious beliefs on health seeking and health provision behaviors: Lessons for theological education review at the University of Botswana." The fieldwork research established that in health seeking, faith motivates adherence to medication while spirituality plays several positive roles to the life of a health seeking person. The findings drawn from a sample of medical practitioners, faith healers, traditional doctors and health seekers indicated that spirituality helps with the healing process. Moreover, research evidence has confirmed that spirituality influences good behavior and health. Additionally, the results of the fieldwork research publication revealed that faith and healing are connected to spiritual aspects (Togarasei, Gabaitiri, Kubanji, Madigele, Mmolai, Shanduka, Tabalaka and Marwiro, 2020).

The fieldwork research also established that Botswana and other nations in Africa may need to re-examine the idea of collaboration between the modern western medical theory and practice, biblically informed faith healing which involves the presence of Christian spirituality and also indigenous medical knowledge provided by African traditional healers. Collaboration of these three in terms of healthcare provision can enhance public health in Botswana and other African states in general. Collaboration of modern medicine, spiritual-faith healing provided by church pastors and healing done by traditional doctors have the potential to improve healthcare provision system especially if the three types of practices refer patients to each other. Referrals can help patients to achieve holistic healing since Africans in general believe that healing can be provided by the three identified systems of healthcare provision. Considering this view, medical education can also borrow from biblical and pastoral faith healing as discussed in the previous passages and African

spirituality emanating from the rich indigenous knowledge on healing and health derived from the continent of Africa.

Overall, the fieldwork research established that religion and spirituality have positive effects on health and medical education. Therefore, in light of these findings, it is necessary that theological and medical education personnel at the University of Botswana and elsewhere in Africa may need to consider reviewing their curricular so as to include courses on the impact of religion and spirituality on human health. Curriculum development in medical schools should also include modules on holistic human health. Such modules may include the importance of Christian faith to the Bible believing patients in hospitals or at home. Other modules may also include the importance of prayer in its abilities to aid healing and the benefits of attending to church for patients who affiliate to different Christian churches.

In addition to the fieldwork research findings, medical education in Botswana can benefit from the work of Levin (2001: 13-14). Concerning the impact of religion and spirituality on human health and medical education, Levin states that, it is necessary for medical education to take into cognizance the seven scientific grounded principles of theosomatic medicine.[1] The first principle shows that affiliation to a religion such as Christianity promotes healthy lifestyles and behavior. The second principle states that fellowshipping with others in a religion has benefits for health. Religious fellowship provides support responsible for buffering the effects of isolation and stress. The third principle shows that prayer and participation in worship have benefits for health through their 'physiological effects of positive emotions.' Fourth principle explains that Christian beliefs benefit health by their similarity to personality styles and health-promoting beliefs. The fifth principle states that simple faith benefits human health as it leads to thoughts of positive expectation, hope and optimism. The sixth principle provided by Levin (2001:14) reveals that mystical experiences have benefits for health since they activate a human life force or healing bioenergy. Moreover, they can also alter the state of consciousness. Finally, the seventh principle states that there is scientific evidence that distant spiritual intercession or absent prayer heals the sick through divine interventions or para-normal means.

While the respondents underlined the importance of religion and spirituality in medical care, literature shows both benefits and challenges. The next sections will discuss these benefits and challenges before proposing a way forward.

Benefits of Integrating Religion and Spirituality in Health Care Systems and Lessons for Medical Education

Spirituality and religion are aspects of human health which a health care system must attend to in its endeavor to address patients' needs. A study conducted by Memaryan, Rassouli, Nahardani and Amiri (2015) revealed that traditional medicine physicians considered spirituality[2] and religion as effective factors in health care provision systems.

[1] Theosomatic medicine, according to Levin (2001:207) is an approach that perceives human health determinants based on the connections between faith in God or God or spirit and the wellness of the body. The theosomatic medical model challenges the psychosomatic approach (body-mind) as insufficient in providing holistic healing of patients. Levin (2001) coined the concept theosomatic medicine after realizing the credible and scientific evidence of the link between body, mind and spirit.

[2] The definition of spirituality is contested. There is no consensus among scholars regarding an agreeable definition of spirituality (Memaryan, et al, 2015). The same also applies to religion as stated in the previous discussion. The definition for spirituality is contested. It is a challenge to differentiate between spirituality and religion. However, the two concepts, spirituality and religion are not synonyms, though they

Although modern medicine physicians have not reached a consensus regarding the impact of religion and spirituality to health and medicine, there are some of the physicians who subscribe to the view that spirituality and religion have a role to play in individual patient's health (Levin, 2001).

The significance of spirituality and religion in people's health and treatment is also raised by D'Souza (2007) who posits that incorporation of the spiritual and religious dimension of patients into their treatment and health management is a need. D'Souza (2007) further reinforces this view by stating that recent surveys on the link between religion and health indicated that separating patients' beliefs and spiritual/religious needs from their care deprives them an important element that is likely to be at the core of their coping and support systems. According to Bolhari, Alivand and Mirzaee (2012), religious and spiritual aspects may be integral to patients' well-being as well as their recovery. Barnett and Fortin (2006) also subscribe to the view that spirituality and religion are significant aspects of human health; however, though these elements of faith are important in medicine and treatment of patients, clinicians must not prescribe religious beliefs or impose their beliefs on patients. If medical practitioners are not trained on how to handle patients' faith needs, it is the trained clergy who can provide in-depth religious counseling to the sick.

Yousefi and Abedi (2011) are also among the researchers who have established the link between religion and health[3]. They state that the doctor who considers the patient's spiritual dimension sends a significant message that he or she is concerned with the person holistically. Moreover, by so doing, the clinician enhances the patient-physician relationship and this may increase the impact of medical therapy and intervention. Lucchetti and Lucchetti (2014) also posit that it is a need for mental health clinicians and other health care professionals to learn about the ways in which spirituality, religion and culture impact on the patients' needs and recovery.

There is need for spiritual and religious care among hospitalized patients (D'Souza, 2007; Lecchetti & Lucchetti, 2014). Similarly, Yousefi and Abedi (2011) state that spiritual needs are part of individual people's essential needs everywhere and at all times. This is so because humans have both physical and spiritual dimensions. These are intrinsic needs of a person throughout life; as such, they are a major element which holistic nursing care system should address. According to D' Souza (2007), satisfying patients' spiritual needs is one of the greatest challenges which nurses face. In their study which utilized a hermeneutic-phenomenological approach, Yousefi and Abedi (2011) arrived at the deductions that spiritual needs are needs which when satisfied cause an individual to grow spiritually thereby making a person social and hopeful individual who thanks God all the times in life. When people grow spiritually, they develop a desire or need to communicate with God as they become hopeful. In this regard, Yousefi and Abedi (2011) concluded

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overlap. Like religion, spirituality encompasses belief in a deity such as god, God or any other supreme being. The discussion of spirituality is centered on the fact that there are ways by which people fulfill what they perceive as their purpose in life according to the divine's provision. Though people adhere to different religions, the concept of spirituality is similar to most of them (D'Souza, 2007). Spirituality according to McCormick (2014) is "a search for that which is sacred in life, one's deepest values; a relationship with God or a higher power transcending the self. People may have powerful spiritual beliefs and may or may not be active in any institutional religion."

[3] The term health according to World Health Organization (WHO, 1949) is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Ai (2008) offers some insights on health by linking it to human well-being; that is being free from injuries experienced during accidents, sickness caused by various factors and also death.

that it is possible to satisfy spiritual needs in the nursing system and when a patient's spiritual aspects are considered, his or her treatment accelerates.

The medical world today, unlike the previous years, has accepted the role of spirituality and religion during interventions and therapies to treat and cure patients. A similar view is postulated by Puchalski (2001) who posits that sometime ago, discussions concerning religion and spirituality were considered inappropriate in the study and practice of medicine. However, this bias is beginning to change as clinicians begin to appreciate the significance of spiritual and religious aspects to health and well-being of patients and the role of faith in the lives of both patients and doctors.

The impact of spirituality and religion in the health of Americans was also revealed by Eisenhut (2016) who posited that faith is a major factor in the lives of the people of America. Eisenhut further states that, despite the fact that individual Americans have diverse cultures, religion and spirituality remain vital to their lives. He cites the Pew Research Center which shows that 65 percent of Americans in 2016 identified themselves as religious while 18 percent described themselves as spiritual. However, regardless of the impact of spirituality and religion in the lives of the people, Eisenhut states that not all medical institutions in the USA take into account patients' religious and spiritual matters as they treat them.

The medical fields in some parts of the USA are disconnected to faith aspects due to the fact that many healthcare providers have been trained during their medical education and practice to look at health and medicine from the mindset of a natural scientist. Having this worldview regarding health, healthcare professionals leave out religion and spirituality outside their health provision and care plans. In consideration of this view, Yousefi and Abedi (2011) state that this is a modern way of looking at medicine which is totally different from the historical times when health care was connected to religion. Eisenhut (2016) concurs with Yousefi and Abedi's (2011) view that in the previous centuries, physicians and spiritual-religious leaders were one and the same. In those years, individuals who were sick and in need of medical assistance looked for a religious guider. However, with the progression of time, there came a period when society decided to separate medicine from the church.

Owing to the importance of spirituality and religion to human lives and health, Eisenhut (2016) urges healthcare providers to be respectful, empathetic and to remain mindful of the patients' spiritual and cultural needs. He stated that there is a proof that a number of Americans are comforted and calmed when they resort to their faith during healthcare trials. Then, finally, Eseinhut (2016) suggested that it is of paramount importance that healthcare providers give patients an opportunity to discuss their religious beliefs with physicians in order to adjust treatments if need be. D'Souza (2007) shares similar sentiments by suggesting that healthcare institutions must educate their staff on how to address different world religions which diverse patients subscribe to. The reason behind the suggestion is that, educating health providers on how to address religious matters helps them gain a sense of awareness thereby doing away with misconceptions on patients' faith issues. Moreover, Barnetti and Fortin (2006) established that exposing healthcare providers to training on matters of religion enhances their ability to engage in valuable conversations with individual patients on their religions as they seek treatment. In addition to this finding, Eisenhut (2016) states that when healthcare providers open communication channels with their patients, it becomes easier to incorporate religion and spirituality in a healthcare system. More so, being vigilant concerning religious and spiritual

practices can speed up patients' recovery, reduction of medical errors and also enhancement of effective communication between patients and healthcare providers.

Aspects of religion and spirituality have positive effects to health and longevity. Amongst scholars who subscribe to this view is Levin (2001) who states that the positive effects of faith to health has prompted some physicians to learn about the extent of the impact of faith in order to use the findings for the benefit of patients. In their endeavor to gather more information on the subject, their research produced evidence that people who attend to religious services on regular basis have recorded lower rates of illness and death compared to those that do not attend regularly or those that do not attend at all.

In the USA, studies on the top three causes of death namely heart disease, cancer and hypertension revealed that people who affiliate to religion have lower rates of the diseases. Another study also established that old people who participate in religious activities have lower rates of depression, dementia, chronic anxiety and less disability (Hall, Koenig & Meador, 2004; Puchalski, 2001). Moreover, the study by Levin (2001) concluded that religious people live longer on average due to the fact that their behaviors and characters are determined by the moral teachings of their religions. The study revealed that most people who are religious avoid behaviors such as smoking and drinking too much which increase the risk of illness and death. Religion and spirituality play a major role in healthcare provision systems.

The above view on the significance of religion and spirituality is maintained by several researchers of which Puchalski (2001:4) is one. Puchalski argues that technological advancement witnessed in the previous decades tended to alter the "focus of medicine, a caring service-oriented model to a technological, cure-oriented model." Puchalski further states that the current physicians particularly those in the USA are attempting to balance the care as they reclaim medicine's spiritual roots. By so doing, they link religion and spirituality with health and medicine. The result of the linkage of these is known as spiritual or compassionate care. Thus Puchalski (2001) views compassionate care as the kind of healthcare which seeks to attend to the person's health holistically. Compassionate care addresses the spiritual, physical, emotional/psychological and social aspects of each individual patient. Therefore, understood this way, compassionate care used in treating patients can be effectively achieved through the combination of bio-medical model added to the practice of addressing a patient' spirituality, psychological and social aspects. This combination altogether produces the bio-psychosocial model of health and medicine. Such a model attempts to address the entire patient' needs effectively.

Holistic intervention strategies to health and diseases are also a requirement in Africa (Byaruhanga-Akiki, 1995). The study conducted in Botswana by Togarasei, Mmolai and Kealotswe (2016) established that health seekers can benefit a lot from a healthcare system that collaborates modern medical practices with those of the traditional and spiritual healing systems. The study also revealed that besides seeking bio-medicine or allopathic health provision alone when they are sick, in addition, Batswana consult traditional and spiritual healers. The reason for combining bio-medicine with traditional and spiritual healing systems by Batswana and other African health seekers elsewhere is that, they believe in holistic healing as Byaruhanga-Akiki and Kealotswe (1995) concluded.

Generally, the African belief is that bio-medicine alone cures the physical ailments of the body, but it cannot address social and spiritual challenges faced by patients. Therefore, Africans believe that spiritual and social challenges can be dealt with effectively by the

traditional and spiritual healing systems whose values are grounded in African religious belief systems, traditional medicine and the Christian-Bible believing church. Overall, the implication is, in an African context, a healthcare system can be more relevant if it combines bio-medicine, religion, be it Christianity and/or African indigenous religions (AIRs) among others. Thus, in an African set-up, medical education can be compliant and relevant if it incorporates the teaching of bio-medicine, traditional-indigenous medical knowledge drawn from African traditional healers and also spiritual-faith knowledge obtainable from the Bible. All churches in their various forms namely mainline, African independent and Pentecostal churches have a role to play in the health of believers. Churches can therefore work in collaboration with healthcare provision systems to enhance health (McCormick, et al, 2012).

Regarding the need for a holistic approach to human health, Ross (2009) perceives that a holistic approach to medicine is the only viable model suitable for addressing human illness effectively. Moreover, Ross (2009) proposes that there is need for integral healthcare whereby complementary and alternative medicine is integrated with conventional healthcare practices. Integral medicine according to Ross (2009) recognizes the fact that people have emotional, mental as well as spiritual dimensions that are very important in the diagnosis and treatment of illness as well as the cultivation of wellness. Similar views are also maintained by Schlitz, Amorok and Micozzi (2005:1) who state that it is integral medicine's concern that a patient should be helped as a whole person, physically, mentally and spiritually. To elaborate this view, Schlitz et al (2005:1) stated that, "Body, mind, and spirit are operating in self; culture and nature, and this health and healing sickness and wholeness are all bound up in a multi-dimensional tapestry that cannot be cut into without loss."

Overall, health and modern medicine should embrace a paradigm shift which calls for integral medical practices. In this case, medicine elaborates the basic model of "body, mind and spirit" into a more inclusive manner that embraces political, economic, social, ecological, metaphysical and worldwide dimension or aspect of healthcare (Ross, 2009:2). Although physicians cannot heal every challenge experienced by human body and life in general, they at least should be cognizant of cultural, spiritual, social and psychological problems in their patients. Moreover, they should also be aware of the implications of failure to consider these aspects of health and healing. Therefore, integral medicine incorporates all dimensions of complimentary, alternative and conventional medicine and healing- from physical, to psychological; cultural to spiritual (Schlitz, Amorok & Micozzi, 2005; Ross, 2009).

It has been, however, noted that, spirituality and religion are vital to patients' lives; as such, incorporating them into a healthcare system yields positive outcomes. Be that as it may, not all public healthcare centers and medical systems address patients' faith needs due to a variety of obstacles. According to Memaryan, et al (2015) there are several challenges which cause certain health providers fail to address patients' spiritual needs. The section that follows examines some of the challenges that act as barriers to incorporation of religious and spiritual needs into healthcare provision systems.

Exploring Challenges that Hinder the Incorporation of Religious and Spiritual Aspects in Healthcare Provision Systems

One of the challenges that seek to hinder the incorporation of religion and spirituality in medicine is lack of consensus on the definition of the concept's religion and spirituality. Considering the relationship between medicine, spirituality and religion, scholars have brought forward two different approaches. Some emphasized the idea of "spirituality and medicine", while others considered the concept of "religion and medicine" (Balboni & Peteet, 2017:3). Those that propose religion and medicine resist spirituality because they are worried about its individualistic connotations and lack of connection to theology. Therefore, if the concept of religion is de-emphasized, then certain beliefs and practices of some religions will be reduced. Proponents of spirituality see religion as only one of the several broad expressions and categories. There are diverse religious practices and cultural beliefs internationally. Therefore, those that propose spirituality approach are of the view that the concept "spirituality and medicine" enables dialogue among varied "religious groups by emphasizing the common starting point of a shared humanity…" Moreover, if spirituality is emphasized over religion, as proponents of spirituality argue, groups which do not fit easily into definitions or religious categories, for instance, those that describe themselves as spiritual but not religious can be easily included. Thus, this view calls for an inclusive approach to facilitate spiritual care to a pluralistic set up made up of religious and those that claim to be non-religious but spiritual (Hall, Koenig, & Meador, 2004; Balboni and Peteet, 2017:3).

Furthermore, another reason why spiritual and religious aspects are not addressed in some health and care provision institutions is that, clinicians lack training in the area of patients' faith (Bolhari, Alivand and Mirzaee, 2012). It is therefore essential that during training in medical schools, doctors and nurses be equipped with skills to incorporate spirituality and religion when providing health care services. The study by Puchalski (2001) reveals that inclusion and integration of spirituality and religion in public health and medicine curricula has long been suggested as an important requirement. Thus, Barnett and Fortin (2006) suggest that modern medical education syllabi should have spirituality and religion as part of the package.

Despite the impact that spiritual and religious aspects seem to have on health, these values are still ignored in practice of medicine particularly in the developing world. For instance, in Iran, Memaryan, et al (2015) established that there is no trace of spiritual and religious related education observed in the country's medical schools. This is quite puzzling considering the fact that Iran is Islamic. Islam is the most dominant religion in the Arab World in which Iran is located. That being said, the situation in Iran is, however, different from that of the USA, a developed country where a number of medical schools have started promoting the inclusion of spirituality and religion in medical education (Barnett & Fortin, 2006). By comparisons, statistics in the USA medical institutions show that, only 3 medical schools addressed the aspects of spirituality and religion in 1993 increasing to 100 in 2011 (Memaryan, et al, 2015). This is not the case with Iran and other countries in the developing world where factors related to religion are sidelined or ignored in medicine.

Despite the fact that there is evidence showing the relevance of including the components of spirituality and religion in medical education curriculum, there are challenges threatening the inclusion of these aspects of faith. D'Souza (2007) cited challenges in academic planning. Memaryan et al (2015) elaborated this view by pointing out that there is lack of necessary content for inclusion in medical education. This challenge

relates to the abstract nature of spiritual-religious aspects and experimental and material nature of bio-medicine. Therefore, these differences between aspects of religion and spirituality and that of health and medicine make it difficult to combine the two. Moreover, Memaryan et al (2015) contend that, so far there is no consensus reached on the definition of spiritual-health. Thus, in several developing countries among them Iran, there is no standard intervention and care model put in place in accordance with the country's context.

Another challenge that acts as a barrier to incorporation of religion and spirituality in public health systems is that, medical education curricula in some contexts is saturated. Therefore, there is no space for inclusion of new components such as spirituality and religion (D'Souza, 2007). Moreover, this problem is coupled with the need for skilled manpower to train medical specialists in religious-spiritual therapy. Therefore, though spirituality and religion have proved to have certain positive effects to health and medicine, their integration in medical training courses is a challenge.

Several other challenges hinder the incorporation of the aspects of religion and spirituality in public health and medicine. For instance, the study by Memaryan et al (2015) shows that in some communities in Australia, religious beliefs and culture can either act as facilitators or inhibitors in the integration of spiritual-religious programs in medical curricula in the university. According to D'Souza (2007), in some parts of Australia, inclusion of spiritual-religious aspects into medical education is not considered a noble idea in the sense that the aspects of faith are of very little value to these communities.

Case studies show that there is diversity in the type of challenges faced by communities, which hinder incorporating spirituality and religion into health and medical practices. In Brazil, according to the study by Jafari, Loghmani and Puchalski (2014), there was lack of time for inclusion of aspects of faith into healthcare system. Moreover, in some cases, people were not aware of the relevance of including spiritual-religious components in medical education. In addition, lack of training in spiritual-religious matters coupled with fear that some patients may not subscribe to spirituality and religion in their lives are some of the barriers to implementation of aspects of faith in the modern public health education system. Most of these challenges according to Memaryan et al (2015) are attributed to the failure of medical schools to provide appropriate development and training in the aspects of religion and faith. Therefore, the non-inclusion of religious-spiritual aspects in medical education's academic curricula is the major barrier hindering modern medicine- heath care providers to provide such care.

Several stakeholders in the field of health and medicine particularly in the developed world acknowledge the need for addressing aspects of religion and spirituality in formal public-health-medical education. Nonetheless, Yousefi and Abedi (2011) state that the implementation of these programs requires a study that explains possible strategies used to overcome challenges in designing and integrating religion and spirituality in medical education.

Professional ethics to some extent acts as an obstacle to the inclusion of religious and spiritual aspects into healthcare systems. In light of this view, McCormick (2014) posits that professional-medical ethics do not require physicians to impinge their beliefs on patients who in most cases are in a vulnerable position as they seek treatment. Moreover, the situation is further complicated by religious and cultural pluralism. There is a wide range of belief systems and varied religious and spiritual practices. There is therefore no physician who can understand all these different religions and faith communities.

So far, the paper has discussed the benefits and prospects as well as challenges of incorporating spirituality and religion in healthcare systems. The section that follows examines how issues concerning spirituality and religion can be addressed in medical schools.

Addressing Religion and Spirituality in Medical Schools

Having realized the significance of religion and spirituality in health and medicine, some providers of public health suggested that the concepts of faith be included in medical education. Research has revealed that in the recent past years, interest concerning religion and spirituality among academic physicians has grown rapidly. Evidence has shown that in the USA, there was a single medical school offering a formal elective course in religion, spirituality and medicine in 1992. However, by 2001, there were above 70 medical schools offering courses on religion, spirituality and medicine (Puchalski, 2001). In some of the medical schools in the USA, courses in religion and spirituality are compulsory. Moreover, these courses are integrated with the rest of other courses in the medical school curriculum. McCormick (2014) posits that integration of religion and spirituality into medicine in the USA was made possible through working together of several healthcare associations. Among these associations according to Puchalski (2001) are the Association of American Medical Colleges (AAMC) and the National Institute for Healthcare Research. These two associations are said to have sponsored conferences on the development of spirituality, religion and medicine curriculum. Koenig (2004) states that the main reason for including spiritual and religious issues into medical school curricula is to enhance holistic treatment and to make medicine more human.

Regarding addressing issues of faith in the USA medical schools, students who take courses on religion, spirituality and medicine have to work with several facets of faith. Moreover, they focus on the clinical integration of the themes of spirituality and religion courses into chronic pain, pregnancy and childbearing; addiction and dependency disorders; psychiatric illness, disability as well as caring for the dying patients. Sessions on religion, spirituality and faith of caregivers are also included. These sessions on religion and spirituality help medical students recognize the religious-spiritual dimension of their own lives and how this can impact their practices at work (Puchalski, 2001). In teaching these sessions, several pedagogical styles are employed. According to Koenig (2004), some sessions provide students with the opportunity to explain or describe their understanding of spirituality and how religion and faith help them cope with the stress of medicine as well as emotions that arise from caring terminally ill patients. Furthermore, Puchalski (2001) states that other courses provide opportunities to practicing doctors to share how they perceive their personal spirituality and how this affects their practice of medicine.

Courses in religion and medicine emphasize the compassionate and spiritual aspect of the bio-medical profession. Compassion is the common most significant theme that student doctors and those already practicing medicine need to realize as servers of people. Providing service to others is considered the root cause of medicine and it is the highest spiritual value (Koenig, 2004; Puchalski, 2017). Therefore, the concept of compassion and palliative holistic care drive several medical education programs which combine diverse methods to teach religion, spirituality and medicine in medical schools. Regarding the teaching methods, Puchalski (2001) posits that there are didactic sessions that cover topics such as the role of religion in healthcare, the part played by spirituality in chronic illness and also in end-of –life care; the use of religion in addressing patients' suffering; how

religion helps patients in seeking meaning and purpose of life in the context of suffering; how to compile a spiritual history and also the roles of pastors/clergy and chaplains in healthcare provision.

In teaching religion, spirituality and medicine courses, Puchalski (2017) emphasizes the need for interdisciplinary sessions delivered by different professionals and providers such as medical doctors, nurses, chaplains, pastors, pastoral counselors and social workers among others. Moreover, in teaching multi-disciplinary courses in medical schools, methods such as storytelling, group discussions, case presentations and discussions; reflective writing; panels where patients, physicians and chaplains among others discuss; as well as the use of literature and poetry to communicate spiritual themes can be used (Puchalski, 2001; Bolhari, Alivand & Mirzaee, 2012).

Curriculum development is one of the most important issues when addressing religion and spirituality in medical education. Though curriculum development has been highlighted elsewhere in the current paper, it has not received a wide coverage. Regarding curriculum development, Mitchell et al (2016) state that though several studies have addressed the integration of spirituality and/or religion curriculum into medical school training, few studies describe curriculum development process that is based on qualitative data gleaned from the faculty and students of medicine. Therefore, in their study, Mitchell and collaborators propose that those who develop the curriculum on religion/spirituality and medicine may explore the perceptions of medical students and pastoral/chaplaincy trainees to facilitate reflection on religious and moral dimensions of caring for critically ill patients and also to train students in self-care practices in order to promote professionalism.

Conclusion

To sum up, the paper has shown that religious and spiritual beliefs play a vital role in the lives of several patients according to Botswana medical practitioners' views. Research has shown that, during a life-threatening illness, several patients seek both physical and spiritual treatment and healing. In other words, patients would be looking for holistic healing that healthcare providers can only achieve if they put into practice or implement bio-psychosocial approach to health in addressing disease. Therefore, through the channels of religion, spirituality and medicine, patients will wrestle with issues of suffering, despair and death while they search for hope and meaning in the crisis of disease and sickness. Furthermore, research has also revealed that religion and spirituality promote good health and longevity to those who take part in faith services at church and others. Finally, though religion and spirituality are different fields of study from medicine, they have a vital role to play in human health and medical education. Inclusion and infusion of the elements of religious and spiritual aspects on health into medical school curricular can be of great benefit to students and those already practicing medicine according to medical practitioners in Botswana. Religion and spirituality are important elements which can enhance public health delivery systems in Botswana.

Tinoonga Shanduka is a trained theologian and a PhD candidate at the University of Botswana. He holds BTh and MA degrees. Shanduka worked for ten years as church

leader in Zimbabwe, two years as World Vision Project facilitator; eight years as a teacher and lecturer in Zimbabwe, plus six years as teaching assistant at University of Botswana. Furthermore, he spent one year as a lecturer at Gaborone University College of Law and Professional Studies.

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