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Integrating Meaning, Purpose, and Spirituality (MPS) Within Lifestyle Medicine Education and Training: Core Competencies to Support Whole-Person Care

Abstract:

Background: Spirituality is a vital, yet sometimes misunderstood component of whole-person care. A growing body of evidence links meaning, purpose, and spirituality (MPS) with improved health outcomes, greater patient satisfaction, and enhanced clinician well-being. In 2024, the American Medical Association (AMA) adopted Resolution 304 (A-24), advocating for the integration of MPS education throughout

medical training and continuing education. Despite previous

accrediting bodies, such as the Association of American Medical

 “Meaning, purpose, and spirituality (MPS) can serve as powerful drivers of sustained lifestyle behavior change, particularly within the context of LM.” 

consensus statements and competencies from other professional organizations and

Colleges (AAMC), the Liaison Committee on Medical Education (LCME), and the Accreditation

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Council for Graduate Medical Education (ACGME), MPS-related competencies remain inconsistently embedded within health professions education, including within lifestyle medicine (LM).

Objective: *To examine competencies, consensus statements and current evidence for spiritual care across various disciplines in order to discern common elements to support the establishment of MPS competencies within lifestyle medicine education and training.*

Results: *The competencies reviewed frame person-centered care through an expanded lens of the human person as biopsychosocial-spiritual. Across disciplines, 5 common categories of competencies emerged, which include: (1) An understanding of whole-person care and broad definitions of spirituality and religion; (2) clinician spiritual self-awareness and self-care, including exploration of potential biases and barriers to patient-centered care; (3) ethical practice, cultural sensitivity, and respect for diversity, including not imposing one's own personal beliefs (or lack thereof) on the patient; (4) spiritual assessment, communication and care planning skills in patient interactions, including team-based collaboration and referral to spiritual care professionals; (5) clinician therapeutic skills, including compassionate presence, active listening, sensitive communication, motivational interviewing and shared decision-making.*

Conclusion: *Incorporating MPS competencies within LM education aligns with the updated pillar of connectedness, recognizing spirituality as a core driver of lifestyle behavior change. Embedding MPS competencies across the continuum of health professions education represents a timely, evidence-based, and ethically grounded step toward*

delivering more compassionate, sustainable, and impactful person-centered care.

Keywords: meaning; purpose; spirituality; medical education; lifestyle medicine; whole-person care

Introduction

Spirituality is a vital, yet sometimes misunderstood, component of whole-person care. With a growing body of evidence linking meaning, purpose and spirituality (MPS) to improved health outcomes and enhanced patient care across diverse populations and conditions, there is increasing recognition of the need to incorporate MPS-related competencies across the continuum of medical education and training for health professionals. In 2024, the American Medical Association (AMA) adopted Resolution 304 (A-24), advocating for the integration of MPS education within medical schools, graduate medical education, and continuing education for practicing clinicians.¹ This builds upon previous consensus statements and competencies from other professional organizations and accrediting bodies, such as the Association of American Medical Colleges (AAMC), the Liaison Committee on Medical Education (LCME), and the Accreditation Council for Graduate Medical Education (ACGME), reflecting the role of all clinicians as spiritual care generalists.²⁻⁴

However, despite the support and recommendations, formal MPS curricula remain inconsistently implemented across health professional training and education, including within lifestyle medicine (LM). With the rising rates of chronic diseases, clinician burnout, and patient dissatisfaction, incorporating MPS into lifestyle medicine education is necessary to promote more holistic, compassionate, and

effective person-centered care. It is also well aligned with the expanded scope of the lifestyle medicine pillar of connectedness—a 2025 modification to the previous pillar of positive social connection—reflecting the essential role of MPS as a prime driver and underpinning of lifestyle behavior change.⁵ This paper summarizes and builds upon key discussions from experts at the 2025 national Meaning, Purpose and Spirituality in Lifestyle Medicine Summit convened by the American College of Lifestyle Medicine (ACLM) and the Global Positive Health Institute (GPHI), with funding support from the Ardmore Institute of Health.

The objective of this work is to examine competencies, consensus statements and current evidence for spiritual care across various disciplines in order to discern common elements to support the establishment of MPS competencies within lifestyle medicine education and training.

Terms and Definitions

Words are interpreted differently based on individual experience, culture, and education. When addressing concepts such as meaning, purpose, religion, spirituality, and self-transcendence, it's essential to recognize that there is no singular, definitive interpretation of these words. However, defining the use of these terms within the context of this paper allows for clarity, consistency, and shared understanding.

Meaning can be described as the *perception* and sense of that which corresponds with our values and priorities, whereas *purpose* is the *expression* of those values and priorities. Overall, life meaning and purpose are typically characterized by the values and priorities of the spiritual domain. From a research perspective, purpose is defined as

“having goals in life and a sense of directedness”⁶ and as a “central, self-organizing life aim that organizes and stimulates goals, manages behaviors, and provides a sense of meaning.”⁷

Religion can refer to the field of religion collectively, including all specific religions, and religious beliefs and practices, typically involving a deity or deities, or that which is greater as the ultimate defining reference point.⁸ Religion may also be described as a faith tradition, typically providing a cosmology or framework for most of the human experience.

Spirituality is described as the deepest domain of human nature, sometimes referred to as an individual’s “being” or “spirit.” This includes one’s worth, relativeness or connectedness, identity, deepest values or priorities, and intentions. When considering a vertical connection, spiritual refers to the human experience of connection with the divine and/or that which is greater than one’s self. From a religious perspective, spiritual may pertain to a religion or be of a religious nature, pertaining to all things related to a supreme God, gods, or higher power(s). This is also sometimes described as internal religiosity. To support a shared understanding of spirituality within a health care context and within this paper, an international consensus statement on spirituality defines it as “a dynamic and intrinsic aspect of humanity through which individuals seek ultimate meaning, purpose, and transcendence, and experience relationships to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.”⁹

Self-transcendence represents the top of Maslow’s Hierarchy of Needs and describes the other-oriented experience of valuing or prioritizing that which is greater over oneself.¹⁰ It is experienced as a connection or unity with a greater benevolent

someone, something, or some purpose, in which one is receiving or finding value. Self-transcendence involves giving value to that which is greater.

Current Competencies and Consensus Statements

The combined impact of MPS on health outcomes has accrued sufficient evidence and attention to justify and inspire the development of medical education competencies, curricula, and consensus statements across medical education. The AAMC, LCME, the Foundational Competencies for Undergraduate Medical Education and the ACGME milestones/competencies for most medical specialties all include MPS-related competencies primarily grounded in concepts of professionalism, communication, and non-discrimination.^{2-4,11} However, these organizations do not list any specific MPS-based curriculum requirements in the context of medical knowledge or skills. The United States Medical Licensing Exam (USMLE) includes MPS within medical ethics, under the heading of “psychosocial and spiritual counseling” in the context of death, dying, and palliative care and within systems-based patient safety, with patient religious factors listed as a potential cause of medical error.¹²

The ACGME requires family medicine residents to recognize the spiritual dimensions of significant life transitions, such as birth and death.¹³ Family medicine physicians are also expected to practice whole-person care, which necessitates an understanding of behavioral, social, and biomedical influences on health. Hospice and palliative medicine ACGME requirements include addressing spiritual needs, to include competency in assessing, identifying, and managing spiritual distress among patients and their families in the context of serious

illness or imminent/recent death.¹⁴ Hospice and palliative care specialists are also expected to be sensitive to religious perspectives relevant to end-of-life care, such as withdrawing/withholding nutrition, hydration, or lifesaving/sustaining care.¹⁴ ACGME psychiatry competencies reference the impact that cultural factors (such as MPS) can have on health throughout life.^{15,16} In addition, psychiatrists are expected to form a therapeutic alliance with patients and families from a variety of backgrounds, as well as identify sociocultural issues relevant to a patient’s specific condition. One milestone is framed in a negative context, requiring that psychiatry residency graduates be able to “describe the influence of... sociocultural... factors on atypical personality development and psychopathology.”¹⁵

Other health professions have also published competencies based on MPS principles; this includes nursing which explicitly endorses the importance of holistic care (mind, body, and spirit).¹⁷ Physician associates are expected to care for patients from diverse backgrounds and religious perspectives.¹⁸ Pharmacists must consider patients’ beliefs and values, and collaborate with them and family members to inform treatment plans.¹⁹

Although it is beyond the scope of this paper to review specific MPS components of individual training curricula, many educational institutions and research groups have explored a variety of competency models or curricula. Many universities are establishing dedicated centers, initiatives, and programs on MPS-based concepts and their impact on health, including George Washington University, Indiana University, Duke University, Baylor University, Harvard University, the University of Arizona, Yale University, Loma Linda University, the University of Chicago, and the University of

Florida. These efforts represent a wealth of knowledge and experience that could be leveraged to develop national, required medical education competencies in MPS, which in turn could shape the educational experience and future practice of clinicians.

In one study, 90% of the deans of U.S. allopathic medical schools reported that their medical school had courses or content on spirituality and health, but only 7% had a dedicated, required course on the subject.²⁰ In addition, only 39% of the deans considered this content as important for their students, yet 25% would consider allocating additional curricular time for these topics. Interestingly, even though the mind-body-spirit unit is one of the central tenets of osteopathic medicine, only 20% of U.S. osteopathic medical schools formally include religion and spirituality in their curricula²¹—a decrease from 50% reported 15 years earlier.²²

While there is a growing recognition of the impact that MPS concepts have on health, most nationally promulgated MPS-based competencies for medical trainees remain grounded in the overarching concepts of professionalism and the provision of non-discriminatory health care. Although several specialties have competencies related to MPS medical knowledge or skills, most of these focus on identifying potential barriers to communication and medical decision-making, or providing end-of-life care for spiritual distress. To date, there is a notable absence of formal professional competencies that specifically prepare health professionals to address MPS as part of long-term therapeutic care.

Competency Categories to Support Whole-Person Care

Examination of competencies and consensus statements for spiritual

care across various disciplines reveals common elements that can support the establishment of MPS competencies within lifestyle medicine education and training. A growing body of literature highlights the benefits of spirituality and religious practice for both mental and physical health^{23,24} and existing guidelines emphasize the integration of spirituality into whole-person care through a biopsychosocial-spiritual framework.²⁵ These efforts build upon the classic 1946 World Health Organization (WHO) definition of health²⁶ and extend Engel's biopsychosocial model²⁷ through the addition of a spiritual dimension.²⁸ This aligns with recent work proposing the inclusion of spiritual well-being^{29,30} into a WHO+ definition of health.^{31,32}

The competencies reviewed frame person-centered care through this expanded lens of the human person as biopsychosocial-spiritual. Across disciplines, 5 common categories of competencies emerge, which include:

- (1) An understanding of whole-person care and broad definitions of spirituality and religion
- (2) Clinician spiritual self-awareness and self-care, including exploration of potential biases and barriers to patient-centered care
- (3) Ethical practice, cultural sensitivity, and respect for diversity, including not imposing one's own personal beliefs (or lack thereof) on the patient
- (4) Spiritual assessment, communication and care planning skills in patient interactions, including team-based collaboration and referral to spiritual care professionals
- (5) Clinician therapeutic skills, including compassionate presence, active listening, sensitive communication, motivational interviewing and shared decision-making.

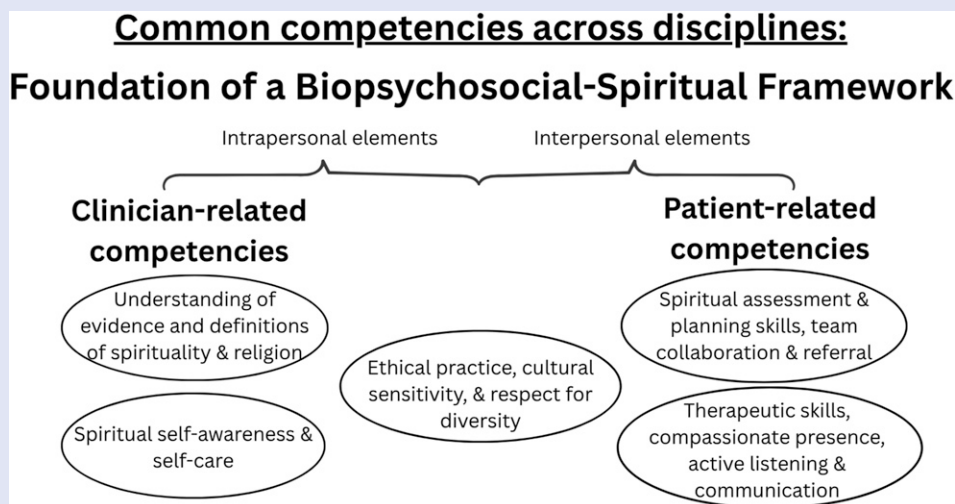
To provide person-centered care, clinicians must address all dimensions of the whole person.³³ This process begins within the clinician (intrapersonal) and extends outward toward the patient (interpersonal).³⁴ On an intrapersonal level, clinicians must first recognize spirituality as an essential aspect of whole-person care, and develop an understanding of how spirituality and religion are defined. This includes self-reflecting on one's own sources of meaning and purpose, which may include spirituality and/or religion. On an interpersonal level, while chaplains and other spiritual care specialists play a central role in attending to complex spiritual needs, health professionals serve as spiritual care generalists, with responsibility to assess for spiritual health during routine clinical encounters and recognize signs of spiritual distress for which referral is warranted.³³ It is essential that clinicians demonstrate cultural sensitivity and respect for diversity in ethical practice, particularly when working with multicultural patient populations.³⁵ This serves as a foundation for patient encounters, guided by 2 primary skill sets: assessment skills and therapeutic skills, as outlined in Figure 1.

Fostering Flourishing

Inherently, working within health care can be a stressful experience, and trainees often demonstrate higher levels of burnout compared to long-time clinicians and age-matched, non-healthcare-trainee peers.³⁶ Among nursing students, reported rates of burnout are as high as 23%, and prevalence among medical residents can reach nearly 50%.^{37,38} Unfortunately, death by suicide has been the leading cause of mortality among medical residents for at least the past quarter century, accounting for nearly twice the number of resident deaths as the next most common cause, and at

Figure 1.

Summary of shared competencies across disciplines, framed within a biopsychosocial-spiritual framework including both intrapersonal and interpersonal elements.



a rate nearly 4 times higher than age-matched, non-resident peers.³⁹ Emerging articles describe the need for educational interventions specifically focused on meaning as an approach to prevent physician burnout.^{40,41} While most of these education interventions focus on medical students,⁴² published studies also encompass residents from a variety of specialties⁴³⁻⁴⁵ as well as learners from other health care disciplines, such as nursing,⁴⁶⁻⁴⁸ social work,^{49,50} and pharmacy.^{51,52}

Recent systematic reviews found that spiritual well-being was associated with lower rates of burnout among health care workers, trainees,⁵³ and medical doctors.⁵⁴ Additionally, religious affiliation has been associated with lower burnout among practicing physicians⁵⁵ and higher levels of psychological well-being,⁵⁶ resilience, and empathy among medical students.⁵⁷ MPS can contribute to a trainee's sense of flourishing through direct impact on their own personal well-being⁵⁸ (via the same mechanisms that benefit their patients, such as improved mental health), as well as a greater

sense of fulfillment in providing care that incorporates MPS as a therapeutic tool.⁵⁹ MPS is a key factor in positive health—which combines healthy lifestyles and positive psychology—offering students and trainees additional health protective factors to support resiliency and to thrive in the face of adversity.⁶⁰ Interventions promoting health care trainee flourishing via MPS include providing protected time and supporting infrastructure for spiritual practices (such as prayer, religious service attendance, meditation, nature walks, and observance of religious dietary guidelines), formal didactics and/or small-group discussions (both on MPS as a therapeutic tool, as well support groups for those from particular religious persuasions),⁶¹ and targeted opportunities to care for patients struggling with a sense of meaninglessness.⁵⁹ An overarching and baseline principle guiding the inclusion of MPS in medical education is that medical educators must hold at least the same openness to, and respect for, the diversity of MPS in medical trainees and

colleagues as clinicians are expected to hold for their patients.

One of the mechanisms by which MPS positively impacts health professional trainee well-being and flourishing is a greater sense of work accomplishment among trainees with higher levels of MPS-based well-being.⁵⁸ Additionally, many clinicians consider themselves to be highly motivated by MPS factors.⁵⁵ Up to one-third of physicians report that they pursued a career in medicine at least in part due to their personal spiritual beliefs.⁶² Promoting a (re)connection with a health care trainee's motivation and purpose for choosing their career is a well-documented method to combat burnout⁶³ and promote flourishing, with interventions such as "reflection rounds" helping health professionals to reignite their sense of meaning within their chosen vocation.⁶⁴

Ethical Practice

Clinicians serve as moral agents who grow in the art and virtue of their craft.⁶⁵ As such, clinicians need to develop specific spiritual or

personal sensitivities along with good habits of caring for themselves and patients to promote proper holistic healing, an emphasis often not included in medical education and training. To fulfill this duty, clinicians and health care teams must provide comprehensive and inclusive care for patients that assists the patients in integrating and considering the full range of their needs.⁶⁶ This care should be *patient-led* and *patient-centered* rather than clinician-controlled. Clinicians must exercise discretion, deliver spiritual care commensurate to patient needs, *understand the limits of their expertise*, and be prepared to refer patients to other health care professionals or denominational leaders when appropriate, especially after finding patient issues that are complex or beyond their scope of practice.⁶⁷ As compassionate and caring professionals, clinicians should strive *to support or accompany patients* seeking health or treatment during illness, as illness can lead to social isolation. Lastly, while accompanying patients, clinicians must exemplify *a certain humility and tolerance of differences* that allows them to be true to their own personal beliefs while being respectful of and learning from those they care for.

Understanding the ethical aspects of spiritual care can help prevent clinicians from making several common ethical mistakes,⁶⁶ one of the most prevalent of which is the misconception that spiritual care falls outside the scope of medical practice. This may result from a lack of common language for spiritual issues, as well as little emphasis on training for existential needs. When clinicians lack awareness about human needs related to MPS it hampers the patient's ability to find deeper engagement in living while receiving medical care. Another frequent misstep stems from ethical concerns of action, where clinicians proselytize or share their faith during

care, often without being asked. A power imbalance exists between patient and clinician, which can "violate the principle of interfaith respect."⁶⁸ This may manipulate a patient into accepting the values of clinicians that may not align with their own culture or perspectives.

Additionally, while supporting others through their life stories, clinicians must maintain proper boundaries between themselves and their patients. Clinicians are not immune to countertransference, which can cause the clinician to act more like a friend than a trusted caregiver.⁶⁸ Countertransference occurs when a clinician begins to relate to the patient as if they were a personal acquaintance, potentially weakening professional boundaries. Each of these oversights undermines the core role of spiritual care as a supportive presence that respects the patient's life perspective. Active reflection and application of these ethical principles requires trainees and practicing clinicians alike to consider and reflect, as doing so elevates patient care from a purely technical act to a potentially transformative moral act.

Spiritual Assessment and Care Planning

Several assessment tools are available to help incorporate a person-centric approach while addressing meaning, purpose, and spirituality (MPS) within lifestyle medicine (LM) education and future practice. While different tools are optimized to specific clinical environments, patient populations, or learning contexts, an important consideration for a tool across all training and education models is the ability to leverage MPS to address deeper motivators that help make LM interventions more complete and sustainable. For students, educators, and clinicians who serve as non-specialists in spiritual care, a simple and straightforward mnemonic is

likely most useful for beginning discussions.

The simple and general FICA (Faith, Importance, Community, Address in Care)^{69,70} and HOPE (sources of Hope, Meaning and Strength, Organized Religion, Personal Spirituality, Effects on Care)^{71,72} tools are among the most studied and applied in learning environments. While each of these tools can be useful for health care professionals in training and practice, the lifestyle medicine clinician will require additional training and frameworks to shift the focus of the tool from a survey aimed to optimize health care outcomes to an entry point in discussions about leveraging MPS for motivated and sustained lifestyle change. To achieve improved integration of spiritual inventories within LM practice, clinicians and training programs should consider a combination of MPS survey tools with motivational interviewing (MI) and coaching skills, to include the 4 core communication skills of MI, commonly known as OARS (open questions, affirmations, reflections, summaries).⁷³ Use of these skills can help to clarify how values or strengths might influence or inspire lifestyle change and maintenance of positive health behaviors.

Current guidelines recommend screening and assessment for spiritual distress using structured approaches, with referral to chaplaincy and other spiritual care specialists when indicated.^{74,75} Validated tools, such as the Spiritual Distress Scale, can assist in this process.⁷⁶ Medical education should include training on how to refer to and work with the spiritual care team to formulate a patient-centered treatment plan that can be mutually reinforced. As in much of medicine, clinicians are often the "generalists" in the spiritual care team, whereas chaplains, clergy, community faith leaders and other spiritual care professionals are the "specialists."⁷⁷

Given that LM clinicians often practice in outpatient settings where the spiritual care team may be less obvious or organized than within an inpatient setting, consideration should be given to cultivating a spiritual care referral network. This may include members of local communities of faith, meditation teachers, as well as health and wellness coaches. As an emerging health profession, MPS-related competencies are now reflected in the required training and education for national board certified health and wellness coaches (NBC-HWC).⁷⁸ This includes understanding the influence of connecting with something greater than oneself, as well as the importance of exploring the personal meaning underpinning desires and needs. This evolution of training and education aligns with a greater understanding of the role spirituality can play in helping to shape health promoting behaviors, particularly in the middle-aged and elderly population and especially in times of stress.⁷⁹

Compassionate Presence

For all clinicians, compassionate presence is a vital and multifaceted element that profoundly contributes to spiritual care in health care settings, benefiting both patients and clinicians alike. *Compassion* is defined as a deep awareness of the suffering of another with an orientation toward action to relieve that suffering.⁸⁰ Compassionate presence develops from combining “altruistic curiosity with a quiet and empathetic presence.”^{81(p20)} Compassionate health care is expected by patients and is a professional obligation for clinicians.⁸² As a therapeutic skill, compassionate presence is itself a deeply spiritual activity. It is not merely a passive act, but an active, relational response that involves holding sacred space and being fully present to the other while actively

listening and refraining from interrupting, judging, or attempting to fix the situation. When the clinician interacts with compassionate presence, both the patient and the clinician experience the exchange as a healing encounter of “existential togetherness.”⁸³ For patients, there is a real sense of accompaniment, solidarity, increased trust, greater well-being, and reduced anxiety.^{82,83} Compassionate presence can foster a deep sense of human connection at a time when patients may be experiencing existential distress and suffering.⁸³

Clinicians also greatly benefit from interactions rooted in compassionate presence. Research shows that it leads to enhanced clinician well-being, increased job satisfaction, and improved clinician–patient relationships.^{33,34,84} Embodiment of compassionate presence is also a protective factor against burnout and compassion fatigue.^{85,86} Through this interaction, the clinician may be able to reconnect with their purpose of being a healer. There are several proposed methods to increase capacity for compassionate presence. Formal programs include awareness-centered deep listening training,⁸⁵ mindfulness and self-compassion training,^{87,88} as well as simple practices such as the compassionate pause,⁸⁹ or the 5-8 second intentional silence or “interpersonal lingering”^{81(p18)} that leads to a deepening of the interaction. Developing compassionate presence is a lifelong process that requires self-awareness and continuous training, clinical mentoring, and experiential learning. Trainees will benefit from the development of strong communication skills that promote empathetic listening, skillful use of silence, and reflection that conveys respect so that patients feel truly heard.

Teaching and Evaluation Methods Across the Learning Continuum

Over the last 30 years, numerous articles have described and/or evaluated educational interventions regarding spirituality and clinical practice, including meaning and purpose within the concept of spirituality.^{42-52,90-96} While teaching and evaluation methods used for MPS are very similar to those used for other clinical skills, notable differences are the challenges associated with the diversity of personal beliefs within the learner cohort, as well as to whom care is provided.³⁵ Therefore, making this content area relevant and acceptable to a broad array of learners requires a careful learner-centered approach,^{97,98} to include an emphasis on cultural humility and demonstration of respectful appreciation of diverse perspectives.

There is a notable difference between the needs of pre-clinical learners (e.g., first-year medical students or nursing students) and learners who have clinical experience and/or ongoing clinical duties (e.g., medical residents, practicing physicians, nurses, other clinicians).⁴² Pre-clinical students do not generally have the array of patient stories as their more experienced colleagues, but they can learn basic skills using cases and standardized patients. However, once immersed in direct patient care, learners typically have very rich and meaningful stories. Therefore, utilizing these stories in teaching and providing learners with a safe space to analyze and reflect on these experiences are impactful ways in which to enhance meaning, purpose and healing in their work as clinicians.⁹⁹ Lastly, training goals for clinicians usually involve fostering behavioral changes that positively impact specific desired clinical outcomes.¹⁰⁰ Kirkpatrick’s 4 levels of training evaluation offers useful guidelines for assessing the

effectiveness of clinical educational interventions and can be directly applied to educational programs for MPS across the learning continuum.¹⁰⁰

Learner-Centered Teaching Approaches

Successful learner-centered teaching approaches^{97,98} reflect the needs of students from diverse backgrounds in both the explicit curriculum (what is formally taught) and the implicit curriculum (what is informally taught). Examples of the implicit curriculum include the diversity of beliefs reflected in the clinical cases used for training, and the diversity of the teachers (cultural/religious and clinical discipline) available to discuss complex cases and situations.

While in 2020 over 84% of medical schools in the U.S. reported that their medical school addressed the relationship between spirituality and health, high-quality descriptions and evaluations of these teaching interventions are not plentiful. A 2022 systematic review of medical school courses on spirituality by Crozier et al found nineteen studies that met their inclusion criteria,⁴² which included both educational methods and evaluations of learners and the course. The most common teaching methods were readings (both research studies and fictional stories), didactics, group discussions, case discussions, reflective writing, role-play, shadowing physicians and chaplains, standardized patients, and patient interviews. Exposure to clinical chaplains was a feature in many, but not all, curricula, with the chaplain involvement ranging from a shadowing experience, to their role as a small group facilitator, to co-course leader. Similar teaching methods are described for curricula designed for pre-clinical nursing,⁴⁶⁻⁴⁸ social work,^{49,50} and pharmacy students.^{51,52}

In addition to the teaching methods described above, those

implementing and evaluating curricula designed for clinicians in practice, such as residents,⁴³⁻⁴⁵ ICU nurses,⁹⁴ psychiatrists,⁹⁵ registered dietitians,¹⁰¹ and interdisciplinary rehabilitation professionals,⁹⁶ describe opportunities for learners to directly apply what they have learned in the context of “real world” clinical setting. This sometimes includes the availability of content expert supervisors in the clinical setting (e.g., clinical chaplains).⁴⁴ Some of these curricula also offer opportunities for learners to debrief their experiences practicing their skills with real patients.⁴⁵ Table 1 provides examples of teaching methods linked to the most common competencies described in the literature for addressing spirituality within health professional curricula.

Incorporating MPS into Lifestyle Medicine Education and Training

Lifestyle medicine (LM) is ideally positioned to integrate meaning, purpose, and spirituality (MPS) into medical education and training. Compared to other models of whole-person care where MPS may be addressed briefly to understand a patient's background or treatment preferences, in LM the clinician quickly learns that an understanding of MPS is necessary for shared decision-making and sustained health behavior change. Rather than simply learning about a patient's background to optimize care provided, lifestyle medicine training and education focuses on working with a patient's priorities, values, and sense of purpose to co-create goals that align with the patient's intrinsic motivations.^{104,105}

The lifestyle medicine residency curriculum (LMRC), developed by the American College of Lifestyle Medicine (ACLM), provides 40 hours of didactic learning and 60 hours of application activities in lifestyle medicine for residents of any

specialty.¹⁰⁶ The LMRC incorporates MPS largely into modules about connection and positive psychology, emphasizing relationships, social support, and purpose as vital to well-being.¹⁰⁶ Additionally, it is expected that trainees completing the LMRC will integrate whole-person care assessments into joint decision-making during required patient visits and application activities. Trainees in lifestyle medicine will find that assessments and interventions in the 6 pillars of LM—optimal nutrition, physical activity, stress management, restorative sleep, connectedness, and risky substance avoidance—are most comprehensive and impactful when they seek to understand and leverage the patient's meaning, purpose, and spirituality.¹⁰⁷

Beyond graduate medical education, there is a pressing need to integrate MPS throughout the continuum of medical education, from undergraduate learning to continuing medical education,¹⁰⁸ as well as within health professions programs (e.g., nursing, behavioral health, nutrition, public health, pharmacy) given the interdisciplinary practice of LM. To meet the growing demand for whole-person care, ACLM has developed curriculum pathways to support the academic integration of LM education aligned with ACLM's core competencies.^{109,110}

Institutions that highly value spirituality may choose to require MPS training, such as embedding modules on spirituality and purpose during orientation or doctoring courses to foster shared purpose among students and faculty. Many programs benefit from a longitudinal/spiral approach, revisiting skills with increasing complexity to consolidate performance over time.¹⁰⁸ Others integrate MPS through longitudinal experiences, pairing trainees with mentors to explore personal meaning and purpose while simultaneously learning to address

Table 1.

Teaching and Evaluation Methods Linked to Competencies.

Competency	Teaching Methods (Examples of Commonly Used Methods)	Evaluation Methods (Examples of Commonly Used Methods)
Knowledge of the role of spirituality in health and well-being • Research regarding Meaning, Purpose and Spirituality (MPS) • Biopsychosocial-spiritual framework for whole-person care • Understanding of concepts (spirituality, religion, meaning and purpose) • Awareness of different worldviews and how these might impact an individual's health and/or health care decisions • Awareness of ethical and boundary challenges to patient-centered spiritual care provision	For all learners: • Selected readings re: research, whole-person care frameworks • Interactive didactics • Guest speakers representing different worldviews • Case studies (in small groups) highlighting ethical or boundary issues For clinicians (e.g., residents, practicing clinicians) • Small group discussions of their own challenging patient care cases	For all learners: • Pre-post knowledge assessments (multiple-choice, short answer responses, or reflections on cases) For clinicians: • Pre-post qualitative interviews regarding their knowledge and approach to patient care (assessing level of sophistication in clinical approach)
Clinician Spiritual Self-Awareness, Self-Assessment and Self-Care • Identify when one's own beliefs or values might be impacting patient-centered care • Identify when one's own spiritual health is depleted and may be interfering with one's ability to provide compassionate, patient-centered care. • Identify and regularly utilize methods and resources for maintaining and optimizing one's own sense of meaning and purpose, and one's own spiritual health and well-being	For all learners: • Self-assessment using clinical tools • Reflective writing with prompts • Journaling • Experiential learning activities integrated into the curriculum • Community building activities For clinicians: Team building activities to improve spiritual well-being and health of the practice setting	For all learners: • Quality and/or frequency of self-assessment & self-care assignments For clinicians: • Evaluation of team functioning • Evaluation of the spiritual health of team members • Evaluation of spiritual health of the practice setting
Assessment Skills (for non-specialists in spiritual care) • Patient-centered spiritual screening and history taking • Non-specialist level, patient-centered spiritual assessment (for experienced clinicians in settings where spiritual care specialists are not available) • Synthesize and communicate findings	For all learners: • Selected readings regarding tools for communication -spiritual history taking & assessment (i.e., FICA, HOPE) • Practice questions on themselves • Observation (in-person, video, role-play) of an "expert communicator" demonstrating these skills • Practice skills and provide feedback using approaches such as role-play and standardized patients For clinicians: • After initial practice using role-play or standardized patients, practice skills with own patients • Clinical supervision/feedback by expert clinician • Small group discussion of challenges and successes in practice	For all learners: • Pre-post knowledge assessments (e.g., multiple-choice) • Observed structured clinical examination (OSCE) skills assessments using standardized patients (tailored to the skill level expected) • Qualitative reflection (written or interview) regarding approaches, challenges and next steps For clinicians: • Direct observation with real patients in own clinical setting with feedback from instructor/observer • Feedback from patients (e.g., patient satisfaction surveys)

(continued)

Table 1. (continued)

Therapeutic Skills (for non-specialists in spiritual care) • Always provide compassionate presence and empathetic listening • Support patients in identifying and connecting with MPS resources most meaningful for them, using motivational interviewing and coaching skills • Integrate patients' MPS beliefs and resources into medical treatment plan, using shared decision-making • Identify when spiritual care specialist referral is needed (i.e., patient is in spiritual distress, patient has theological questions or concerns, patient has specific ritual needs) • Identify when one should seek assistance from other members of the health care team and/or spiritual care specialist (e.g., challenges pertaining to differences in beliefs)	For all learners: • Selected readings, including non-fiction re: healing • Small group discussions and/or reflective writing exercises regarding challenges and resources to help maintain ability to provide compassionate presence • Practice skills with role-play and/or standardized patient cases designed for each specific therapeutic skill, with feedback • Observation of spiritual care specialists providing patient care • Small group discussions regarding challenging situations (e.g., general discussions, cases) For clinicians: • After initial practice with role-play or standardized patient, practice skills in own clinical setting • Clinical supervision/feedback by expert clinician • Small group discussions of challenging "real world" experiences	For all learners: As above • Pre-post knowledge assessment • OSCE skills assessment • Reflection assignments For clinicians: • Direct observation & feedback • Patient feedback • Practice-based clinical outcomes (e.g., quality of treatment plans, appropriateness of referrals, etc.)
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^aCompetencies in this table are a simplified summary derived from the national consensus competencies for family medicine residents,¹⁰² and medical students,⁹ and the international consensus competencies (EPICC) for nurses and midwives.¹⁰³

^bTeaching and evaluation methods are examples from this literature review.

these topics in patient care.¹¹¹ Some programs offer month-long required or elective courses in whole-person care, providing concentrated exposure to MPS within interdisciplinary team settings. When considering a format for incorporating MPS into LM medical education and training, leaders should plan for practical risks, including faculty workload and burnout, as well as learner disengagement from content not aligned with assessment or perceived clinical competence.¹¹² Addressing these challenges provides clear reasons to embed MPS skills into observed patient encounters, checklists, and grading rubrics.¹¹¹

Resources and Considerations for Educators

To support the integration of MPS curricula, educators may consider

ready-to-use faculty resources, such as the Interprofessional Spiritual Care Education Curriculum (ISPEC). Developed by the George Washington Institute for Spirituality and Health (GWISH), ISPEC offers a tested, case-based online curriculum for interdisciplinary teams offering spiritual assessment, communication, care planning, and implementation.^{113,114} While not purpose-built for lifestyle behavior change, this curriculum could be paired with MI and LM teaching to ensure trainees consistently translate spiritually derived motivation into shared decisions and sustained behavior change. Regardless of the chosen structure, MPS is most effectively integrated into case-based, person-centered learning.^{115,116} Small-group discussion and reflection rounds help trainees process complex cases and integrate MPS priorities into

team-based care, with demonstrated feasibility and educational value in medical school settings.¹¹⁷ Dedicated LM-focused OSCE's that include MPS assessments as core competencies can further cement these skills by demonstrating how shared decision-making shifts when values and purpose are leveraged to motivate behavior change. For practicing clinicians, interactive workshops and case-based conference sessions offer ongoing opportunities to apply these approaches to real-world cases and sustain faculty development.¹¹⁸

Next Steps for MPS in Lifestyle Medicine Education

Spiritual health is an essential component of whole-person care and falls squarely within the scope of health professional practice,

including within the medical field of lifestyle medicine (LM). It is the responsibility of clinicians and health care systems to address spirituality as part of routine clinical care not only to meet patients' multidimensional needs, but also to uphold moral and ethical standards of care. Doing so requires the systematic inclusion of spiritual care education in both undergraduate and graduate health professions training, as well as ongoing continuing medical education for practicing clinicians across health professions. Meaning, purpose, and spirituality (MPS) can serve as powerful drivers of sustained lifestyle behavior change, particularly within the context of LM. Applying MPS to clinical encounters supports shared decision-making and the adoption and sustainability of LM interventions by anchoring a deeply held belief and purpose to a desired health change.

To align with the recently expanded scope of the American College of Lifestyle Medicine (ACLM) pillar of connectedness, recommended next steps for MPS integration with LM education include the integration of the MPS-specific intrapersonal and interpersonal competencies outlined in this paper within the established LM core competencies, specifically expanding upon "The Role of Connectedness and Positive Psychology" section.¹¹⁰ It is recommended that the evolved core competencies then serve as a blueprint from which to shape curricula across the medical education continuum—including undergraduate, graduate and continuing medical education—as well as health professions programs seeking designation as an ACLM Partial Academic Pathway or Full Academic Pathway.

Embedding MPS competencies within health professions education represents a timely, evidence-based, and ethically grounded step toward delivering more compassionate,

sustainable, and impactful person-centered care. While chaplains and other spiritual care specialists play a central role in attending to complex spiritual needs, the literature supports health professionals serving as spiritual care generalists, emphasizing clinicians' responsibility to assess spiritual health and recognize signs of spiritual distress during routine clinical encounters. The interpersonal experience of compassionate presence as an active, relational response is "spirituality in action."³³ This "existential togetherness"⁸³ strengthens the therapeutic alliance and offers reciprocal benefit to both patient and clinician. Notably, clinicians and trainees with higher levels of spiritual well-being have been shown to experience lower rates of burnout,^{53,54} underscoring the personal and professional value of MPS integration across health professional training and education.

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