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Original Article

Designing and Developing Educational Objectives for Spiritual Health of Family Physicians: A Qualitative Study

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Abstract

Background: The spiritual dimension, one of the four aspects of holistic care, becomes even more crucial during critical times and illness. As family physicians need to support the enhancement of their patients' spiritual health, the development of a comprehensive curriculum for training family physicians in spiritual health could be beneficial. This study aimed to design and develop educational objectives for spiritual health tailored for family physicians using an educational design model, considering four key factors.

Methods: A qualitative content analysis was conducted in this study to explore the perceptions of experts, graduates, and family medicine residents regarding the needs and capabilities related to spiritual health education. A total of 20 family medicine residents, specialists, and experts in spiritual health were selected using purposive sampling. After data collection through interviews, the data were analyzed qualitatively using conventional content analysis. Then, educational objectives for spiritual health were developed based on the identified needs and capabilities, with consensus from specialists.

Results: To identify educational needs, 29 subcategories were extracted from the coded data. Categories with similar meanings were combined, resulting in four primary themes: spiritual knowledge, spiritual attitudes, spiritual skills, and spiritual personality. Ultimately, specialists agreed on the educational objectives for spiritual health, resulting in 9 general objectives and 39 behavioral objectives.

Conclusion: Based on the identified educational needs, both general and specific behavioral objectives for spiritual health were established. Considering the comprehensive, holistic, and culturally relevant nature of family medicine, as well as the differences in the context of the Islamic-Iranian culture, these educational objectives were developed in a specialized and practical manner for family physicians, with an emphasis on enhancing the spiritual health of both service providers and recipients.

Keywords: Educational needs assessment, Spiritual health, Family physicians

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Introduction

The spiritual dimension is one of the four key aspects of holistic care and is equally important as the biological, psychological, and social dimensions of human beings (1). Spirituality represents the higher aspect of human existence, which is inherent in all individuals, serving as a path toward achieving perfection (2). Recently, the impact of spirituality on healing and recovery has attracted increasing attention (3). Studies have demonstrated that individuals with spiritual inclinations tend to respond more effectively to challenges, manage stressful situations more efficiently, and experience better health outcomes (4-6). In times of crisis, especially during illnesses, spirituality becomes even more significant. During critical conditions, the importance of spirituality and spiritual needs becomes more apparent, and patients are more inclined to seek spiritual care (7).

Spiritual health is a distinctive force that harmonizes the physical, psychological, and social dimensions, playing a vital role in coping with illness. This religious coping strategy is considered a crucial resource for more effective disease management and contributes to the maintenance and enhancement of patients' self-esteem, fostering a sense of purpose and meaningfulness in life, increasing psychological comfort, and promoting hope (8). Spiritual health is a condition that operates at various levels, influenced by an individual's capacities, insights, inclinations, and necessary abilities for spiritual

growth (which is proximity to God). In this state, all internal resources are harmonized and directed toward overarching goals, with voluntary internal and external behaviors aligned with these spiritual objectives in relation to God, oneself, society, and nature (9). While improving spiritual health may not cure a disease, it helps individuals feel better, prevent certain health issues, and adapt to illness or death. Spiritual interventions, alongside other interventions, contribute to the balance of body, mind, and spirit, which is a step toward achieving complete and comprehensive health (10).

In the family physician model, the health perspective is central to the physician's role, with the ultimate goal of maintaining and enhancing community health. This involves providing health services within a defined package to individuals, families, populations, and communities, regardless of age, gender, economic, and social characteristics, or disease risk. Given the broad scope of family medicine and its integral connection to various aspects of life, and considering the Islamic-Iranian cultural context in contrast to secular Western culture, family physicians need to receive the necessary training in preserving and enhancing Islamic spiritual health. This training will enable them to promote spiritual health within the Iranian community. Since patients have not only physical needs but also spiritual needs that impact their recovery process, family physicians should address these spiritual aspects and respect patients' values and beliefs to perform their duties more effectively. Such tasks become much more feasible with appropriate training in providing spiritual care to patients (11).

To address the issue of spiritual health within healthcare services, it is essential to provide the necessary training. Research has indicated that one of the reasons for the lack of focus on this topic in healthcare settings is the absence of professional education in this area, suggesting that training in this field is the missing link (2). It appears that the medical education system in Iran is deficient in preparing self-efficacious students, with a notable gap in addressing spiritual health. As such, there is an urgent need for reform within the medical education system, with an emphasis on spiritual health as a priority (12). Globally, discussions surrounding spirituality have become a hot topic within medical scientific circles. Studies indicate that 59% of medical schools in the UK and 90% of medical schools in the US incorporate courses on spiritual health into their curricula (13). Given this, spirituality must be incorporated into the curricula and educational programs of medical disciplines. A spiritual curriculum that incorporates Islamic spiritual concepts through educational programs can provide scientific and clear strategies for achieving professional competencies by setting precise educational goals and implementing appropriate planning, as physicians' behavior is often shaped by the training they receive (14).

Goal-setting is the fundamental element in curriculum planning in the design process. All curriculum theorists have identified goals as a fundamental element of effective curriculum development. When educational goals are not clearly articulated and aligned with educational needs, there is no valid basis for selecting content, teaching methods, materials, and tools (15). Behavioral objectives specify the type of behavior and skills that learners are expected to achieve after the acquisition of particular knowledge. These objectives serve to explicitly outline the cognitive, behavioral, or emotional outcomes expected from learners during a learning experience. Therefore, this study sought to explore the perceptions of experts, graduates, and family medicine students regarding educational needs and to develop educational objectives for spiritual health.

Materials and Methods

This study was conducted in two phases. The first phase involved a qualitative content analysis using Zhang's eight-step process (16) to identify the educational needs related to spiritual health. Based on the results of the needs assessment, a list of expected competencies for learners related to these needs was developed. The inclusion criteria included experts in spiritual health and family medicine, as well as family medicine residents and graduates. The conclusion criterion was the unwillingness of participants to engage or continue cooperation in the study. Purposive sampling was employed, beginning with targeted selection and continuing until data saturation was achieved. A total of 20 individuals, based on the inclusion criteria, were gradually included in the study from May 2021 to July 2021, and individual interviews were conducted with them. Throughout this process, the researchers aimed to select participants with maximum diversity in terms of gender, age, marital status, education, occupation, and place of residence. Many graduates and family medicine residents had extensive experience as family physicians in the healthcare system, which provided valuable and relevant insights on the subject.

To ensure the accuracy and strength of the qualitative data, the study adhered to the four criteria outlined by Lincoln and Guba: credibility, dependability, confirmability, and transferability. The researchers enhanced the credibility of the study by spending a long time in the research environment, interacting sufficiently with participants, obtaining accurate information, and verifying it with the participants themselves. Dependability was ensured by repeating data collection and analysis step by step and using the review of supervisors and experts. Moreover, interviews were conducted at regular intervals without long intervals, with transcription and coding completed promptly. The interviews, codes, and categories were regularly reviewed by the research team to ensure the trustworthiness of the findings. Additionally, feedback from university professors, including their approval and additional comments, was used. Moreover, to increase the transferability of the study, the researchers provided a comprehensive description of the research

process, allowing for the evaluation and applicability of the findings in other fields.

In this study, data were initially collected through semi-structured, in-depth individual interviews, which were conducted either face-to-face or via virtual platforms, depending on any logistical constraints. Before each interview, the researchers explained the study's objectives to the participants. With their consent and agreement, the researchers arranged the time and location of the interview. The location was preferably chosen within an educational setting based on the participant's preference. Additionally, both the researchers and the participant exchanged contact information to facilitate any follow-up questions or clarifications and to coordinate additional sessions, if needed.

Data saturation was reached after interviewing eighteen participants. To ensure that no new data would emerge, sampling was stopped after conducting two additional interviews. Immediately after each interview, the content was transcribed and read multiple times, and initial codes were extracted. These codes were then merged and categorized based on similarities, leading to the identification of underlying content themes.

In the next phase, a draft of the educational objectives for spiritual health was reviewed in several sessions based on the experts' opinions. Subsequently, the educational objectives of the program were examined by a panel of experts in spiritual health, which led to a consensus among specialists and the finalization of the program objectives.

The ethical principles used by the researchers in the research included: clearly explaining the goals and methodology of the research to participants, obtaining their informed consent, ensuring confidentiality of all topics, explaining the purpose of audio recordings, and remaindering participants that their involvement in the research was voluntary, with the option and the possibility to withdraw from the study at any stage. Furthermore, the researchers respected principles of confidentiality in quotations and authorship rights.

Results

In this research, codes, subcategories, categories, and themes were identified. Upon completing 20 interviews and further extracting subcategories based on the interview codes, the research team developed a total of 29 subcategories (steps three to seven of Zhang's analysis), as depicted in Table 1.

Subsequently, during the data analysis process, the 29 subcategories were grouped into categories based on semantic similarities and heterogeneity among them. Through continued examination of the subcategories, 10 categories were established according to steps three to seven of Zhang's analysis method (Table 1).

At the end of the seventh step in Zhang's eight-step process, categories with similar and related semantic and conceptual content were consolidated, leading to the extraction of themes. At this stage, four themes were identified based on the extracted categories (Table 1). Following this, the research team and external reviewers conducted a revision and refinement of all stages of the analysis according to Zhang's eight-step process, finalizing the subcategories, categories, and themes. Thus, the first phase of the research (the qualitative phase) regarding the educational needs of family medicine residents was completed and compiled.

Table 1. Themes, Categories, and Subcategories of Education

Themes	Categories	Subcategories
Spiritual knowledge	Foundations of spiritual health	Theology (God knowledge)
		Anthropology (Human knowledge)
		Worldview (Philosophy of the world)
	Foundations of spiritual health	Nature of spirituality
		Nature of spiritual health
		Spiritual medicine
Spiritual attitude	Importance and necessity of spiritual health education for family physicians	Impact of spiritual health on other dimensions
		Existing gaps
		Holistic approach in family medicine
		Continuity of services
	Outcomes of addressing the spiritual dimension	Building trust
		Establishing effective professional relationships
		Enhancing service quality
	Prerequisites for spiritual communication	Examining religious commonalities
		Patient readiness for acceptance
Spiritual skill (performance)	Determining spiritual need	Establishing spiritual communication
		Obtaining spiritual history
		Spiritual diagnosis
	Spiritual intervention	Preparing interventions
		Implementation
		Evaluation
		Identifying and addressing barriers
		Considerations for specific groups
Spiritual personality (pattern)	Desired level of spiritual health for family physicians	Absence of materialism
		Enhancing spiritual health for family physicians
		Virtuousness
	Practical training in spiritual health	Clinical training
		Scientific and practical mastery of the instructor
		The instructor as a role model

In the subsequent section, according to the eighth step, the researchers present the data report. Initially, each theme and its corresponding categories are described, followed by an exploration of the educational needs for spiritual health in family medicine, based on the identified themes.

Spiritual Knowledge

Based on the common themes extracted from participants' responses, the concept of "spiritual knowledge" was developed, forming the central theme. One of the

educational needs for spiritual health in family medicine residents is the acquisition of relevant knowledge and the understanding of the fundamentals of spirituality, which includes subcategories such as theology, anthropology, and ontology. The theme of connecting with the divine and relying on a higher power was frequently mentioned by participants. One participant stated, "Ancient physicians were very reliant on God and trusted in Him for treating patients and sought His help" (religious expert). Another participant remarked, "Doctors need to be repeatedly informed in workshops that they should not only focus on the physical aspects of the patient and vital signs but also consider the spiritual aspect and their connection with the divine, addressing their stresses and filling this gap" (medical professor).

Belief in the presence of God and recognizing Him as a witness to one's actions and deeds were highlighted as fundamental principles of spiritual health. One participant noted, "The caregiver should constantly see God as an observer and ensure that all moments of service are dedicated to God, internalizing this" (medical professor). Given that various dimensions of human health are interconnected and physicians work with humans, they must first develop a deep understanding of human nature. One participant commented, "One of the topics that should be included in educational objectives is anthropology, to have a good understanding of humans and be able to convey this understanding" (specialist physician).

Some participants expressed a need to understand the nature of existence and the human relationship with creation, which are integral parts of spiritual health. A family medicine specialist stated, "Understanding the fundamental essence of existence, knowing the purpose of our existence, where we are going, and the outcome of this world." Many experts noted that many spiritual concepts are not sufficiently covered in the educational program for family medicine physicians. Even fundamental concepts such as the mission of medicine and the value and dignity of sincere service reveal educational gaps. Moreover, definitions of spirituality and spiritual health, along with their nature and dimensions, need to be clarified for residents. One participant described their learning needs as follows: "Defining spiritual health, understanding how to achieve spiritual health, and strategies to attain spiritual health" (family medicine resident).

Spiritual Attitude

The importance of spiritual health, its necessity for family physicians, its consequences, and the conditions for spiritual interventions, as expressed by participants, were grouped under the more abstract theme of "Spiritual Attitude". This reflects individuals' perspectives, attention, understanding, and inclination toward spiritual health, emphasizing their relevance and similarities.

Physicians typically focus more on clinical or physical symptoms, as well as obvious psychological signs. However, a significant issue that patients face may be related to the peace derived from religious beliefs and convictions, which they lack, potentially contributing to their anxiety or other health issues. One participant noted, "We need to work on valuing this aspect of health for students so they give it special importance and genuinely seek to help individuals through enhancing their spiritual health and intervening accordingly" (medical faculty). Due to a lack of interest, time constraints, and other reasons, spiritual health does not hold particular significance among healthcare personnel. Clarifying the importance of spiritual health for family medicine residents can foster their inclination to learn about and apply this dimension in practice.

The study's results indicated the necessity of elucidating the role of spiritual health for family physicians to enhance their willingness to learn about and apply it. One participant highlighted, "Since physicians lack an understanding of spiritual health, we first need to educate them by demonstrating its relevance and incorporating it into medical education" (medical faculty). Clarifying the results and implications of spiritual health, which was identified as another educational need, can influence attitudes toward it. As one participant stated, "Attention to the spirituality and beliefs of patients helps in their recovery, and strengthening the spiritual dimension of patients contributes to the overall health of the community, helping patients to be satisfied with God's will, trust in Him, and remain hopeful for His grace and kindness" (family medicine resident).

To enhance the spiritual health of family physicians and their patients, the necessary infrastructure must be provided. Shared religious beliefs and readiness for acceptance among patients can foster an environment conducive to spiritual care. A participant remarked, "Shared religious convictions between the physician and patient can promote health, and simultaneously, efforts to achieve physical health combined with strengthening spiritual health will make the concept of overall health more attainable."

Spiritual Skills (Performance)

The categories for identifying spiritual needs and spiritual intervention, as mentioned by instructors and residents, were conceptualized under the title "Spiritual Skills (Performance)", reflecting the need for practical action. The first step in implementing spiritual health and determining a patient's spiritual needs is establishing a proper connection between the physician and the patient. One participant noted, "Healthcare providers are among the few people with whom patients share their pain, suffering, and many personal issues that they might not be able to discuss with others. This can create a foundation for a deep connection and understanding between the provider and the patient" (family medicine resident).

Once a proper spiritual connection is established, it is necessary to take a spiritual history. As one participant

noted, "Family medicine residents should observe patient cases in clinics, obtain spiritual histories from patients, set goals for enhancing spiritual health, implement interventions, and ultimately become proficient" (medical faculty). The spiritual history obtained from the patient guides the physician toward a spiritual diagnosis. "Methods for diagnosing spiritual health issues in patients should be taught" (medical faculty).

After identifying the patient's spiritual challenges and diagnoses, the family physician must take appropriate actions to address them. It is essential to define the necessary actions and specify the proposed content of interventions. One family medicine resident commented, "The content should address the place of God in human life and how we see God's presence in every part of the human body. Even the entry and exit of a single ion can cause cellular disruption and sometimes death. Who organizes and purposefully arranges these cells? Revisiting and relating human physiology to God and surrendering to His will gives hope to both the physician and the patient."

After developing spiritual content, appropriate actions must be taken to address spiritual needs. One participant remarked, "Spiritual needs are those that give meaning to a person's life. If we take steps to address these needs, it creates a sense of satisfaction in individuals and advances spiritual health" (family medicine resident). Another participant stated, "Therapeutic strategies to enhance spiritual health and gradually move toward the desired goal should be taught" (medical faculty). The curriculum should therefore include appropriate spiritual interventions. Another participant remarked, "Life skills based on spiritual skills and problem-solving methods with a spiritual approach should be considered in spiritual health discussions." However, the implementation of spiritual interventions may face certain obstacles that need to be identified for successful execution. One participant said, "Medical students should be given an overview and consider limitations. For example, someone with a foundational understanding of spiritual health should be taken into account. We should perform the task to the best of our ability and not lose hope, but also be aware that our beliefs might not change. If we do not succeed, it remains a limitation. We cannot completely alter their spiritual health." Additionally, specific conditions and groups should be considered when implementing spiritual interventions. One participant highlighted, "For individuals with illnesses, physiological changes in the body may lead to increased acceptance and a greater inclination toward meaning, especially in those with physical health issues" (family medicine specialist).

Spiritual Personality (Model)

The emphasis on practicality in spiritual health and practical training, as expressed by participants, was conceptualized under the title "Spiritual Personality." Several comments and statements from participants illustrate and support this theme. In the context of spiritual health, it is crucial to be pragmatic, meaning that spiritual health should be evident in both the physician's and the patient's actions. One participant noted, "Spiritual training is feasible and very necessary, but it is challenging to find instructors who are themselves well-versed in this field and can convey this sense of meaning to students" (family medicine specialist). Another participant remarked, "Perhaps knowledge can be taught through specific methods, but spiritual health is more complex. It involves more than just words, handouts, and books. Our behaviors are the determining factors, known as the hidden curriculum" (medical faculty). As one participant pointed out, "The instructor should teach medical students about spiritual health in such a way that they can see it both in the instructor's words and actions and wherever they are present at the patient's bedside, they can say, 'My instructor acted this way'" (medical faculty).

In the next stage of the research, competencies and educational objectives were determined based on expert opinions. A draft of educational objectives for spiritual health was reviewed in several sessions with specialists. To finalize them, a group of spiritual health experts reached a consensus. Ultimately, nine general objectives and thirty-nine behavioral objectives were formulated as the educational goals for spiritual health (Table 2).

Discussion

The present study identified several general objectives categorized as follows: The objectives related to familiarizing participants with the fundamentals of spiritual health and understanding the concepts of spiritual health and spiritual care were derived from the theme "Spiritual Knowledge." The general objectives related to recognizing the importance and necessity of spiritual health education for family physicians, understanding the outcomes of addressing the spiritual dimension, and understanding the basics of spiritual communication emerged from the theme "Spiritual Attitude." The general objectives pertaining to the identification of spiritual needs and the implementation of spiritual interventions were derived from the theme "Spiritual Skills (Performance)." Finally, objectives aimed at achieving an optimal level of spiritual health in family physicians and understanding the hidden curriculum of spiritual health were derived from the theme "Spiritual Personality."

A similar study by Rasooli et al focused on needs assessment and the development of educational objectives for spiritual care programs for nurses. They identified 25 needs and formulated three objectives: 1) Enhancing individual self-awareness from a spiritual perspective, 2) Clarifying the role of spirituality in the nursing profession and its place in nursing care, and 3) Preparing nurses to provide spiritual care (17). Although their target group was nurses, some needs and objectives aligned with those of the present study. Categories related to fundamental concepts of self-awareness and performance were similar across both studies. However, the current study identified

Table 2. Formulated Objectives

No.	General Objectives	Behavioral Objectives The student should be able to:
1	Familiarity with the fundamentals of spiritual health	- Explain the monotheistic perspective. - Describe the relationship of humans with themselves, God, others, and nature from a monotheistic perspective. - Apply the monotheistic perspective in health services.
2	Familiarity with the concepts of spiritual health and spiritual care	- Define spirituality and spiritual health. - Explain the relationship between spirituality and spiritual health. - Describe the background of spiritual care. - Explain the characteristics of spiritual care with examples.
3	Understanding the importance and necessity of spiritual health education for family physicians	- Explain the impact of spiritual health on other dimensions of health. - Clarify the importance of spiritual health in other dimensions. - Analyze the current status of spiritual health education. - Explain the relationship between the holistic approach of family medicine and spiritual health education. - Describe the connection between the continuity of family medicine services and spiritual health education.
4	Awareness of the outcomes of addressing the spiritual dimension	- Explain the impact of addressing the spiritual dimension of the patient on building trust, with examples. - Describe the effect of addressing the spiritual dimension of the patient on establishing an effective professional relationship. - Illustrate the impact of addressing the spiritual dimension of the patient on improving the quality of services, with examples.
5	Understanding the basics of spiritual communication	- Assess the patient's religion. - Inquire about the patient's views on their adherence to religion. - Evaluate the patient's readiness to establish a spiritual connection.
6	Understanding how to assess spiritual needs	- Explain the principles of establishing a spiritual connection. - Establish an appropriate spiritual connection with patients. - Describe the principles of obtaining a spiritual history. - Obtain an appropriate spiritual history from the patient. - Identify types of spiritual diagnoses. - Make an appropriate spiritual diagnosis for the patient.
7	Familiarity with the implementation of spiritual interventions	- Explain the characteristics of spiritual intervention. - Develop an appropriate spiritual intervention. - Describe how to implement a spiritual intervention. - Execute an appropriate spiritual intervention. - Explain how to evaluate a spiritual intervention.
8	Achieving the desired level of spiritual health in family physicians	- Internalize God-centeredness within oneself. - Enhance one's own spiritual health. - Adhere to moral virtues.
9	Understanding the hidden curriculum of spiritual health	- Explain the components of the hidden curriculum of spiritual health. - Apply the components of the hidden curriculum in one's own learning. - Effectively model behavior after the actions of the instructor.

many educational needs and objectives that were not covered in the study by Rasooli et al, which utilized a comprehensive methodology.

A similar study in 2014 titled "Spirituality and Health: Expanding the Field" investigated the competencies required for spirituality in healthcare across seven medical schools in the United States. The results identified six areas of final competency: 1) Healthcare Systems, 2) Knowledge, 3) Patient Care, 4) Humanistic Presence, 5) Personal and Professional Development, and 6) Communication (18). This study highlights that the competencies related to spirituality within healthcare need more precise definitions and further examination.

A study by Memariyan et al defined three domains for medical students: 1) Concepts related to spiritual health from the Islamic perspective, 2) The importance of spiritual health and its impact on other aspects of health, and 3) Addressing spiritual matters in providing health services (19). These findings align somewhat with the themes identified in the present study, with the distinction that this study extracted a fourth theme titled "Spiritual Personality." This theme highlights the importance of involving individuals with moral virtues and spiritual characteristics in the training of family medicine assistants. These individuals should serve as role models, demonstrating appropriate spiritual behavior, thereby becoming practical examples for clients and trainees.

Family medicine assistants need to become familiar with the fundamentals and concepts of spiritual health at the outset of their training. Within the current medical education system, it is essential for medical students, particularly at the basic science and clinical education levels, to gain a deeper understanding of spiritual health as an important dimension of health and a healthy lifestyle, both theoretically and practically. According to some participants, spiritual health is viewed as a personal journey to explore and address questions about life, meaning, and connection with a sacred or transcendent force, which may lead to the development of a meaningful cognitive framework in individuals. Therefore, to implement spiritual health effectively, this sense of meaning should be integrated into the educational content and philosophy (18,20). A study conducted in Turkey further indicates that only 47% of students possessed adequate knowledge of spirituality and spiritual care, with this knowledge being acquired throughout their studies over time. Additionally, 53% of students reported a lack of knowledge and

awareness in this area (21).

Spiritual health involves a system of values that guides individuals toward self-transcendence and personal growth. Among the factors influencing the practical teaching of spiritual health are religious values, which often intertwine with concepts of religion and spirituality. Spiritual health is frequently associated with common religious practices such as prayer and supplication. In Iranian society, which is influenced by religious values, spirituality for many individuals often equates to religious tenets and principles. Experts argue that the effective transmission of concepts such as spirituality, professional ethics, and other cultural and social issues in medical education occurs through the hidden curriculum. The hidden curriculum primarily focuses on the underlying attitudes, cultural contexts, and values, which are influenced by the prevailing culture in educational and healthcare settings. Teaching spirituality aligns with the transformation of the existing medical paradigm. It goes beyond mere knowledge acquisition and emphasizes attitudes and behaviors, making it ideally suited to be conveyed through the hidden curriculum (22).

Paying attention to the outcomes of spiritual health significantly impacts the development of a positive attitude toward this topic among family physicians. Repeated observation of these outcomes and understanding their connection to professional activities can lead to a greater focus and greater inclination toward the subject. Numerous studies highlight the benefits of spiritual health, including an improved lifestyle, reduced engagement in risky behaviors, increased health-related behaviors, better physical health, enhanced coping abilities, and increased ability to provide social support to others (23).

This study demonstrated that doctors and nurses need to be familiar with the skills to assess and identify the spiritual needs of their patients. This enables them to make appropriate diagnoses and subsequently offer the necessary spiritual care, considering factors such as the patient's age, type of illness, and specific circumstances (e.g., terminally ill patients, patients in intensive care units, or deceased patients). Participants identified the ability to establish effective communication for providing spiritual care as an essential requirement. In Rasooli's study, the goal of spiritual care education was to equip nurses with tools to assess spiritual distress, identify signs related to spiritual concerns, determine the spiritual needs of patients and their families, and understand how to initiate and conclude communication for spiritual care. This includes skills such as empathetic presence, religious and cultural sensitivity, bioethical considerations, complementary medicine, delivering bad news, and interacting with patients and their families. Building trust-based relationships with respect and sensitivity to patients' beliefs is also emphasized (17). Likewise, in a study in Taiwan aimed at designing and implementing a spiritual care training course, one of the course elements was the concept of spiritual distress, categorized by chronic and acute illness. This component was identified as a spiritual diagnosis in the current study.

Modeling and role-playing, particularly through educators with high moral and spiritual qualities, is one of the most effective strategies for promoting spiritual health at all levels of the educational system. Spiritual teachers are individuals of high integrity, dedication, and responsibility who perform their duties with the utmost care. They view their activities as being under the watchful eye of God, who is aware of both their inner intentions and outward actions. Through their sincere efforts, they create a sense of responsibility and contribute to a spiritually enriching environment in higher education.

Various spiritual role models can be incorporated into the higher education system for health. The identification, selection, introduction, and promotion of their scholarly, social, and personal life practices depend on the preferences of educators and a deep understanding of the audience's needs. The concept of the hidden curriculum refers to the implicit and indirect transmission of messages within educational environments, focusing on cultural customs, norms, values, attitudes, skills, preferences, and social and behavioral expectations. In this context, the sender, the environment, and the method of message exchange are as important as the content of the message itself. The role of the hidden curriculum is more pronounced in the clinical stages of medical education, where the behaviors of instructors and other individuals who serve as role models, as well as the overall educational atmosphere, significantly influence students' personalities, particularly in their interactions with patients. Although the hidden curriculum seems to leave its effects in an implicit and sometimes unintended manner, with effective and planned interventions and the active and impactful involvement of instructors, it can foster desirable outcomes in students (24).

Conclusion

To develop the knowledge and skills of family physicians in providing comprehensive and complete services to patients and clients, they must be prepared to offer spiritual care. This objective cannot be achieved without completing relevant training programs, and organizing such courses requires the development of well-defined educational plans. The first step in creating educational programs is identifying educational needs and formulating objectives based on these needs, which this study has addressed. The results of this study can be used to design curricula for spiritual health in general medical education and continuous education programs, especially for physicians working as family doctors after their general training and those undergoing family medicine residency.

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Competing Interests

The authors declare no conflict of interests. All authors have read and agreed to the published version of the manuscript.

Ethical Approval

Ethical approval was granted for this study by the Ethics Committee of Qom University of Medical Sciences (Code: IR.MUQ. REC.1399. .204).

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