



Factors affecting spiritual care practices of oncology nurses: a qualitative study

Soolmaz Moosavi¹ · Camelia Rohani² · Fariba Borhani³ · Mohammad Esmaeel Akbari⁴

Received: 10 April 2018 / Accepted: 24 July 2018 / Published online: 31 July 2018
© Springer-Verlag GmbH Germany, part of Springer Nature 2018

Abstract

Purpose Spiritual care is a component of the holistic nursing approach. But in practice, nurses face many challenges during the implementation of spirituality care. Thus, the aim of this study was to explore the barriers and facilitators affecting spiritual care practices by oncology nurses.

Methods This qualitative study was conducted using a conventional content analysis based on semi-structured interviews with 25 participants, including cancer patients and their family members, oncology nurses, physicians, psychologist, and spiritual researcher-therapists.

Results The results showed that the two main themes of the study, “spiritual competency” and “spiritual inefficiency” in healthcare organization, were two major factors in implementing spiritual care practices for cancer patients by oncology nurses.

Conclusions The findings of this study emphasize the necessity of developing coherent spiritual care programs in hospitals and removing administrative barriers. Teaching spiritual care in nursing courses at schools and continuing education programs for training of healthcare team members are necessary. Likewise, forming a spiritual care team with oncology nurses at the center and defining their members’ roles and responsibilities are essential. Hospital managers can also make fruitful steps by establishing a monitoring system and identifying the needs and barriers for spiritual care in oncology settings.

Keywords Spiritual care · Obstacles · Facilitators · Cancer patient · Oncology nurse · Spiritual care team

✉ Camelia Rohani
camelia.rohani@sbm.ac.ir; cameliarohani@yahoo.com

Soolmaz Moosavi
moosavi.soolmaz@yahoo.com

Fariba Borhani
faribaborhani@msn.com

Mohammad Esmaeel Akbari
proposalcrc@yahoo.com

¹ School of Nursing & Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

² Community Health Nursing Department, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Hashemi Rafsanjani Hwy, Valiasr Street, Tehran, Iran

³ Medical Surgical Department, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

⁴ Cancer Research Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran

Introduction

The prevalence of chronic diseases, such as cancer, is on the rise worldwide. The World Health Organization has predicted that the incidence of cancer will rise from 14.1 million in 2012 to 24.6 million in 2030 [1]. This increasing incidence in Iran is also significant [2]. In GLOBOCAN 2012, (IARC) 85,000 new cases of cancer were reported in Iran, a number that will reach 156,000 by 2030 [1]. These statistics highlight the importance of both paying special attention to this disease and providing thorough treatment and care for cancer patients [3]. Evidence reveals that mere significant advances in biomedical fields are not sufficient to provide quality care and meet all needs of cancer patients. Significant progress in early diagnosis and treatment of cancer increases the life expectancy of patients [3]. But, cancer with unexpected presence and change in the meaning and purpose of life underline the spiritual needs of cancer patients in their care [4].

Spirituality is a concept that typically refers to human’s search for finding a meaning, and purpose for life and death

[5]. Spiritual care is part of palliative care [6]. In this area, interventions are used to improve the relationship of human with himself, others, God, and nature, so that he could find a meaning for his life [7]. In patients with cancer, some concerns, such as fear of recurrence, constantly trying to find a fault with somebody cause problems in making a relation to both oneself and others [4, 8]. Also, some thoughts about spirituality such as being punished by God, feeling of guilt, divine judgment, divine justice, and compliance may create misconceptions in the patients' mind which, in turn, might lead to "spiritual distress" [7]. According to the holistic viewpoint of nursing care, spiritual needs and spiritual care have also been emphasized in the nursing theorists including Florence Nightingale and Jean Watson [9–11]. Thus, spiritual care of cancer patients is an important caring. However, despite the importance of spirituality in the nursing profession [12], it has largely been ignored in practice compared with other care dimensions [9].

An overview of studies on patients' attitudes toward spiritual care shows that their expectations from the healthcare system were mostly on routine care with an emphasis on the physical dimension. Although 50% to 59% of patients believed spirituality is important issues during the treatment [13, 14], they reported that their spiritual needs were not met during the course of the disease [3]. The nurses' perspectives toward spiritual care [15–17] indicated that they had a positive attitude and believed to have adequate knowledge about spiritual care; however, they did not know how to use the concept of spirituality and the internal forces of patients in their caring practice. In practice, nurses are not able to perform spiritual care for patients [15–18]. In some studies, the importance of teamwork with main responsibility of oncology nurses to provide spiritual care has been recommended [15]. However, the composition of this team and the individual responsibilities of the members have not clearly been addressed. Evidence shows that they mentioned time limitation as an obstacle to provide spiritual care for patients [18]. Furthermore, identifying spiritual needs of patients has not been their patient care priority; and they relinquish this aspect of care to other persons. The healthcare system did not pay enough attention to the implementation of spiritual care in contrast to other care dimensions [14, 19, 20]. Therefore, this source of patients' recovery [21–23] has been largely neglected [9, 19, 24]. Even in Iran, despite the tight relationship between Islamic culture and the concept of spirituality, applying spirituality in the recovery of patients has been ignored [15–17].

Despite all advantages in accepting spiritual health care, it seems that the spiritual dimension has remained unclear in care programs for different reasons such as the obscurity of the spirituality concept and attitudinal-behavioral barriers. Several studies using quantitative methods and related tools have been conducted in this field [25–27] and most of them are surveys that merely deal with nurses' attitudes and

perspectives about spiritual care. In addition to individual factors, the role of environmental factors is also important in the provision of these care, and also since the number of qualitative research in this area is few (especially in Iran), we decided to get a deeper vision and tried to explore this issue (factors affecting the provision of spiritual care to oncology nurses) more profoundly using experiences from patients, families, oncology nurses, and other healthcare providers in the oncology wards in Iran.

Methods

This qualitative study, with content analysis approach, is part of a larger study. The first author attended the oncology department of three educational hospitals affiliated to medical sciences universities in Tehran. In one hospital, a relatively coherent spiritual care was provided by a spiritual care team in the oncology ward. In two other hospitals, there was not a spiritual care team in oncology wards but oncology nurses acknowledged to provide spiritual care for patients when it is necessary. Therefore, in order to have a more variation in samples and have access to participants involved in coherent and non-cohesive spiritual care, it was decided to use both places.

In this study, 25 participants were selected by purposive sampling method. The inclusion criteria for cancer patients were as follows: having at least 18 years of age, and being physically and mentally able to participate in the study. The inclusion criterion for healthcare team members was having at least 6 months of work experience in the oncology department. Moreover, having at least two research studies on spirituality and also having experience in offering spiritual care were the inclusion criteria for a spiritual researcher-therapist.

Data collection was conducted using 25 semi-structured interviews with open-ended questions. The sample interview questions were as follows: Patient: Please explain about the type of caring that you got here by oncology nurses? Did you get spiritual care by the nurses here? Could you please tell me about your experiences? Based on your experiences what do you think about facilitators? Based on your experiences what do you think about problems? Nurse: Please explain about the type of caring that you gave to their patients here, how is it about the spiritual care? Could you please tell me about your experiences? Based on your experiences what do you think about facilitators? Based on your experience what do you think about problems? Family member, Physician, Psychologist and Spiritual-researcher therapist: Please explain about the type of caring that your patient got here by the oncology nurses? Did your patient get spiritual care here by the nurses? Could you please tell me about your experiences? Based on your experiences with your patient, what do you think about facilitators or factors which can help to the nurses

to do spiritual care in the system? Based on your experiences what do you think about barriers or preventing factors for oncology nurses to do spiritual care in the system?

During the interview, using more in-depth questions, deeper questions were asked on spiritual care practice. The place and time of the interviews were selected by agreement and permission from the participants. Interviews lasted from 15 to 60 min (35 min on average). Interviews with nurses and doctors were conducted in a private room at the workplace. The patient interview was done in the patient hospital room. Interviews with family members also took place at the hospital area. Spiritual researcher-therapists were interviewed at different places, at their workplace in hospital or university (according to their request).

No new categories or concepts were found after analyzing the 23 interviews. However, two more interviews were conducted to become completely sure about the data. Data analysis was performed using conventional content analysis by Graneheim and Lundman [28]. First, the entire text was carefully read to understand the overall sense of the text. After reading the text for several times and immersing in the data, the units of the analysis were characterized and the key meanings were extracted and the initial codes were formed. Then, these codes were organized based on similarities and differences found in subcategories and categories [28]. Afterward, the similar codes were placed in one subcategory and similar subcategories formed the categories. The data were analyzed by MAXQDA 10 Software.

To validate and accept the data, the first author spent considerable time to collect, understand, and analyze the data. After coding the interviews, they were reviewed and evaluated by the research team members. For data verification, analyzed interviews were given to five participants of the study. Then, three faculty members (with doctoral degrees in nursing and adequate background knowledge about research in the field of spiritual health, spiritual care, and also being an expert in the methodology of qualitative research) were asked to read the interviews, codes, and extracted categories. The audit was also

done by four external supervisors (three persons with a degree of doctoral in nursing and a background of research in the field of spiritual health, and one oncologist) for reliability of the data. Despite the limitation of transferability in qualitative studies, the authors attempted to describe the method section of the study in details, including selection of the participants, data collection, and data analysis to enable the readers to evaluate the application of data in other researches [29].

In this research, all the essential points related to ethical considerations were observed and Ethics Code IR.SBMUPHMN.1395.576 was obtained from the Research Committee of the University. The first author introduced herself to the participants and explained the research objectives, the process of studying, and interviewing process to them. Informed oral and written consent of the participants were obtained. The participants were also assured about the confidentiality of their responses. Finally, it was explained to the participants that they had the right to withdraw at each stage of the study without any adverse consequences.

Results

Tables 1 and 2 present the demographic characteristics of participants. Twenty-one subcategories, seven main categories, and two themes were obtained from the extracted codes (Table 3). The two themes were “spiritual competency in the healthcare organization” and “spiritual inefficiency in the healthcare organization.” Table 3 shows example quotations for some subcategories.

Theme 1: Spiritual competency in the healthcare organization

In the context of oncology nursing, it was unclear which competencies are important to provide spiritual care. The theme of the study entailed five categories.

Table 1 Demographic characteristics of participants (patients and family members; $n = 9$)

Participants	Sex	Age (years)	Religion	Education level	Duration of the disease	Type of cancer
Patient	Female	45	Islam	PhD	8 years	Breast
Patient	Female	63	Islam	College	1 year	Colon
Patient	Female	45	Islam	College	6 years	Colon-lung
Patient	Female	63	Islam	Bachelor of Science	2 years	Sigmoid
Patient	Male	66	Islam	High School	3 months	Pancreas
Patient	Male	22	Islam	College	2 years	Maxillofacial
Patient	Female	53	Islam	Bachelor	1 year	Colon-liver
Family member	Female	47	Christian	College	–	–
Family member	Female	59	Islam	Bachelor of Science	–	–

Table 2 Demographic characteristics of participants

Participants	Sex	Age (years)	Educational level	Work experience (years)
Nurse	Female	38	Bachelor of Science	16
Nurse	Female	39	Bachelor of Science	16
Nurse	Male	28	Bachelor of Science	3
Nurse	Female	33	Bachelor of Science	12
Nurse	Male	49	PhD in Nursing	28
Nurse Aide	Female	41	CNA (certified nursing assistant)	11
Physician	Male	45	Oncologist	15
Physician	Male	58	Oncologist	29
Physician	Female	46	Specialist in Palliative Medicine	15
Physician	Male	52	Specialist in Palliative Medicine	22
Psychologist	Male	53	PhD Degree	34
Spiritual Researcher-Therapist	Female	44	Specialist in Community Medicine	6
Spiritual Researcher-Therapist	Male	36	PhD. in Ethics	5
Spiritual Researcher-Therapist	Male	46	PhD. in Quran and Islamic Resources	14
Spiritual Researcher-Therapist	Male	38	Master of Science in Philosophy	2
Spiritual Researcher-Therapist	Male	44	PhD. in Islamic jurisprudence	23

The category of “facilitating relationship” refers to the acceptance of roles and coordination in the relationship between the patient and the healthcare team members. Also, education in category of “coordinated training” is a key element in changing the attitude and awareness of oncology nurses about spiritual care. This key element is important from the childhood to adulthood period. “Professional readiness” of the oncology nurses is another factor. Characteristics like ethical features, religious beliefs, kindness, and ability to communicate, having a good conscience, being responsive, and energetic can assist the oncology nurse to practice spiritual care. An “organizational spiritual culture” plays an important role in encouraging and supporting the provision of spiritual care. Moreover, supervision on planning and implementing spiritual care programs should be carried out at all levels in the hospital.

Theme 2: Spiritual inefficiency in the healthcare organization

Inefficiency at various levels of the healthcare organization is a deterrent to practicing spiritual care. Practicing spiritual care will not be done in the healthcare organization if there is no sensitivity to it. This refers to the category of “attitude-behavioral restriction.” “Uncoordinated environment” also contributes to non-implementation of spiritual care for cancer patients. Lack of funding and training courses, inexperienced novice oncology nurses, lack of time, and high workload are some of the environmental factors which might affect the practicing spiritual care by oncology nurses.

Discussion

The present qualitative study explored the factors affecting the practicing of spiritual care in patients with cancer by oncology nurses. Extracted themes from the data were “spiritual competency” and “spiritual inefficiency” in the healthcare organization. Competencies have been described as abilities, skills, knowledge, motivations, or traits in terms of behaviors for job proficiency [30]. Spiritual competency in the organization requires the cooperation of elements at all levels of the health system in order to achieve the common goal. Based on the experiences of participants in this study, “spiritual competency” as one of the influencing factors on the practicing spiritual care included “facilitating relationships,” “coordinated training,” “professional readiness,” “organizational spiritual culture,” and “supervision”.

Facilitating relations and constructive interactions, inside and outside of the healthcare organization, is necessary for management, planning, and implementation of spiritual care. Further, the study revealed that the implementation of spiritual care needs awareness and sensitivity of policy-makers at the highest levels of health care system for the planning of spiritual care and the design of a spiritual care team, consisting of physicians, nurses, clerics, social workers, and psychologists. On the other hand, given the complexity of the concept of spirituality and its relation to human dimensions, the provision of spiritual care requires the communication and participation of interdisciplinary team members with relevant expertise.

A review of the studies shows that communication of the nurse with doctors, clergymen, and patients are referred to as a

Table 3 Categories, subcategories, and quotations of the study

Categories	Subcategories	Quotations
Facilitating relationship	Informed authorities	“Authorities must monitor the current situation accurately and plan for it accordingly”(P _n 20, Sp RT)
	Interdisciplinary communication	“As I cannot take a medical order as a cleric, a doctor cannot go to the pulpit, so we need to interact and go ahead and plan together” (P _n 20, Sp RT)
	Coordinated therapists	“One of the most important issues regarding spiritual care is that the patient understands the spiritual care provided by the nurse and it is also approved by the doctor and the doctor is in line with the team” (P _n 15, N)
Coordinated training	Teaching children	“In order to prevent all these spiritual distresses in adulthood, it is necessary to plan a change in the interpretation of death and life for the child” (P _n 24, Sp RT)
	Practicing spiritual care in skill lab	“We need to practice spiritual care and, as the instructors teach different procedures and evaluate them, it is needed to teach and evaluate spiritual care in the nursing courses “(P _n 11, N)
	Nurse training	“Holding spiritual self-caring training courses for nurses is the most important step for them to provide spiritual care” (P _n 17, Sp RT)
Professional readiness	Spiritual interaction	“The art of establishing communication was very important. One time, we had an illness that had a fight and did not speak to anyone. I went to see him. He was a tall man with a strong body and big arms, but his morality was very sparse and did not get along with anyone. The conditions of his arms recalled the position of Abbas’s religious figures to me ... In summary, I could communicate with him what I wanted to do (P _n 19, Sp RT)
	Individual features	“There is a nurse here who is very energetic; but the other nurses are not like her” (P _n 15, P)
	Having moral virtues	“The nurse should tolerate patient. A nurse as a spiritual care giver Does not care about his patient” (P _n 15, P)
	Belief in religious foundations	“You tell me, is there any difference between the nurse who wants to take a vessel ... and says “In the Name of GOD” and the person who take a blood vessel simply?” (P _n 7, P)
Organizational spiritual culture	Positive attitude toward spirituality	“My attitude toward cancer treatment is patient-centered instead of disease-centered. So, I know that as much as chemotherapy is important, spiritual care is also important “ (P _n 23, Ph)
	Appropriate pattern	“Always say to the personnel, work with conscience, and always know that God is seeing you, so if you do not, you will not do the wrong thing” (P _n 10, N)
Supervision	Hospital evaluation	“A part of the clinical governance and accreditation of hospitals should be dedicated to practicing spiritual care” (P _n 25, Sp RT)
	Documentation	“We must ask the nurses to report on the provision of spiritual care and everything they do in the field, like all other work in the daily nursing report, in order to be documented like any other action” (P _n 25, Sp RT)
	Student evaluation	“The nursing mentor should observe and evaluate the ability of the student to communicate with the patient, time for the patient, patience and patience to answer the patient’s questions ...” (P _n 12, N)
Attitude-behavioral restriction	Unawareness of the spiritual dimension of care	“A nurse should care about patient’s physical condition, one has a seizure, one has a pain, another one has a fever, etc.” (P _n 6, P).
	Prioritizing physical care	“You know, when I talk to a patient, I’m worried that I will not get to the rest of my life” (P _n 3, N)
	Not sensitive to spiritual care	“You know one of the most important obstacles is the attitude of the indifferent policy-makers who say that we cannot think of the dimensions of care such as spiritual care when we have such basic problems in providing physical care and physical well-being to our patients.” (P _n 4, N)
	Assignment of spiritual care to others	“At all, the hospital is not in a position to do this. It is imperative that spiritual care be given elsewhere and treated by other people” (P _n 6, N)
Uncoordinated environment	Human factors	“In my opinion, not everyone should be in the oncology section, especially the newly graduated nursing school students” (P _n 11, N).
	Organization factors	“One of the most important problems is lack of funding, which prevents some care interventions” (P _n 20, Sp RT).

P_n number of participants, Sp RT spiritual researcher-therapist, N nurse, Ph physician, P patient, F family member

spiritual care facilitator [30, 31]. Koenig also described the importance of forming a spiritual care team in his paper [32]. Our findings are in line with previous studies and show that if the nurse and physician would agree and support spiritual care, the patient will show a greater confidence in the care provided by clergymen or other spiritual care team members which, in turn, causes the patient to benefit more [7, 33]. VandeCreek states that although the attendance of clerics is important in the hospital, health care providers do not usually allow others to take care of the patient. They only consult with their colleagues about the patient. He also introduces a difference between assessing the spiritual needs of a patient by a nurse or cleric as one of the ambiguities [34].

The coordinated training category developed based on the participants' experiences emphasizes three aspects of childhood spirituality education, the teaching of spiritual care in the student's period and in the clinical practice in nursing profession. Paying attention to spiritual care as a transcendental care since childhood is of great importance. It seems that with regard to the relationship between spirituality and religion, religious resources can be used to teach spiritual self-care and to prevent spiritual distress from childhood period.

On the other hand, many studies have referred to the academic teaching of spiritual care for the implementation of nurses [27, 30, 31, 35]. Studies have also focused on the impact of spiritual education on the sense of spiritual wellness, the improvement of quality of life, peace, and job satisfaction [36]. However, the review of studies shows that recent studies have not focused on the content of spiritual care education, spiritual care education methods, and nurse-patient communication techniques for assessing the spiritual needs of patients. Therefore, interventional studies to examine the effect of providing spiritual care education on the ability of nurses to provide spiritual care should be considered.

In the case of nursing students, most studies have investigated students' attitudes toward spirituality [16, 17] while based on the results of our study, studies should also be conducted to assess students' needs to spirituality and effective factors, and then make desirable changes in their curriculum in order to enhance awareness, their willingness, and ability to provide spiritual care for patients. Accordingly, researchers' suggestions is to include the lesson of nursing religious jurisprudence in the nursing curriculum in undergraduate and graduate level and planning for training of Faith-Community Nurses or Parish Nurses that does not exist in Iran.

Another important finding of the study is the professional readiness for spiritual care. This facilitator includes the ability to engage in spiritual interactions, individual characteristics, having moral virtues, and belief in religious foundations. Abbasi reports that a nurse can provide spiritual care only if he or she understands the value of spiritual care and knows

about the art of communicating with cancer patients [37]. Based on the experiences of participants in our study, having religious beliefs in nurses, reading religious books, and prayers for patients can be a good source of spiritual care for patients. According to religious teachings, man must perform his responsibilities in relation to himself, God, surrounding people and nature in order to elevate spiritually [38]. Having belief in a unique God and trusting him in all conditions, especially in hard situations, is one of the important aspects of spiritual care that helps patient be calm. In all religions, attention to the presence of God considerably affects work conscience and accountability [7]. It, however, should be noted that despite the close relationship between spirituality and religion, it does not necessarily mean directing and correcting the religious beliefs of patients [7, 27, 39].

Another finding of this study is the spiritual culture of the organization. This category embraces two pillars of positive attitude toward spirituality and appropriate patterns in the health care organization. Nurses, nursing tutors, and nurse managers can be good models for students and other novice nurses in the hospital. They can play an important role in the transfer of professional values [40]. Koren points out in his study that a positive attitude toward spirituality and the existence of a spiritual support system in the nursing work environment is of great importance. He points out that nurses should have the opportunity to express their spiritual experiences in order to help patients [41]. Grant's study revealed that nurses did not have the opportunity and support to express their experiences in this regard [42].

Supervision of spiritual care as the last resort of facilitators of providing spiritual care to patients is in fact a feedback to provide care and attention to the weaknesses and strengths of the program. It is important to monitor the performance of health care centers and staff, document all activities carried out in this area, and monitor the performance of nursing students to improve the quality of nursing care and professional performance [43]. An important implication of this finding is the accreditation program for hospitals. Paying attention to spiritual care in the program of validation of health centers can facilitate the implementation of spiritual care. Assessing the performance of oncology nurses, based on the reports and documentation in the patients' file, not only determines the effectiveness of the spiritual care provided and the extent to which they achieve the goals but also determine their educational and follow-up needs. It also determines the training programs needed by nurses in the future. Supervisors, therefore, should have the readiness and skills to do this [44]. In the case of spiritual care, it is important that individuals who are really competent do the supervision task.

Another theme of this study is "spiritual inefficiency in the healthcare organization" including two categories of

“attitudinal-behavioral restrictions” and an “uncoordinated environment.” Based on our findings, behavioral-restrictions can be the result of a lack of understanding of the spiritual dimension of care, non-sensitivity to spiritual care, and, therefore, prioritizing physical care and giving spiritual care to other people. The findings of our study showed that nurses considered searching for patient beliefs inappropriate or did not know how to enter this area. The lack of attention to the teaching of the fundamentals of anthropology, ontology, and spiritual health care in the nursing schools and training of nursing students is a major obstacle to practice spiritual care for cancer patients [7, 38]. Given that the concept of spirituality is ambiguous and also because in the health system, the main emphasis is on the advancement of science and technology based on objective phenomena, these two points have caused a further decline in the implementation of spiritual care. On the other hand, nursing students who have not received targeted spiritual care during their studies will continue to attend physical and traditional care after completing their education at work because of lack of appropriate patterns and support for the implementation of spiritual care [19, 27, 44].

The uncoordinated environment category refers to the inadequacy of human resources, organizational factors, and facilities. Spiritual care, as well as other aspects of care, requires the provision of conditions and facilities. Lack of efficient human resources, lack of suitable space for individual and group counseling sessions, and lack of access to the library, teaching aids, and prayer facilities, and other essential facilities, reduce the possibility of implementing spiritual care. In our cultural context, although nurses believe in the importance of religious sources, they have not been trained to use these resources. Additionally, although the existence of a spiritual care team and the presence of a cleric who is knowledgeable about medical science can help, but there is virtually no such a team or even if it exists, it is informally engaged.

In summary, the authors found that in this cultural context, nurses in the oncology wards need supports from policy-makers of the health system to provide spiritual care to patients and move from an inefficient pole to spiritual competency in the organization. Planning to remove the barriers of spiritual care seems to be the first step in implementing these cares. Neglecting policy-makers and planners to provide adequate and efficient human resources, assessing the status quo, measuring nursing education needs, developing health indicators, standards, and in particular developing clinical guidelines lead to delaying the provision of spiritual care to patients. The lack of knowledge on spiritual care, lack of a spiritual care team, and lack of clarity on the responsibilities of oncology nurses in this area, as the most important barriers, make the oncology nurses not have a holistic attitude about providing care to their patients which, in turn, causes them to ignore the

spiritual needs of the patient. While planning for coordinating education as a facilitator, an assessment of the content of spiritual care education makes oncology nurses prepared for spiritual care.

Strengths and limitations of the study

The specific religious and cultural feature of the context in which the present study was conducted makes it distinct from other related studies. The study findings were of great help to take further steps forward and provide a spiritual care guideline for cancer patients in the study context. One of the strengths of the present study is its sampling diversity and interview with a variety of participants including the cancer patient, family members, oncology nurses, physicians, and spiritual researcher-therapists in the oncology wards. In this study, a Christian patient was also invited to participate in the study, but unfortunately he did not accept our invitation. However, his family members agreed to participate in the study. It seems that limited access to non-Muslim participants is one of the study limitations that might affect the generalizability of the results.

Conclusions

The findings of this study show that “spiritual competency” and “spiritual inefficiency” were two important factors in practicing spiritual care to cancer patients. In this regard, progress with planning and commitment in practice to increase awareness, sensitivity, and positive attitudes toward spiritual care in oncology nurses and at different levels of a healthcare organization leads to decrease negligence and consequent inefficiency in this field. It is hoped that cohesive training programs will be developed utilizing the relationship between spirituality and religion and with regard to the culture and the patient and family member needs. In such circumstances, it is obvious that due to the essential role of oncology nurses in practicing spiritual care, spiritual health care education programs should be planned on the priority of oncology nurses’ regular training programs and nursing curriculum in different educational levels at nursing schools. Spiritual care can be implemented and evaluated in practice by establishing a formal spiritual care team and defining tasks and the role of its members. In such a suitable environment, the trained oncology nurse will recognize the spiritual needs of the patient and understands what level of spiritual care, how, and by whom should be presented.

Acknowledgments The present study is a part of the findings of the doctoral Thesis. Authors thank and appreciate all cancer patients, their family members, and healthcare team members as well as spiritual researcher-therapists participating in this study.

Authors' contribution SM and CR did the planning and design of the study. This study was supervised by CR. SM was the leading author for drafting of the article and responsible for identifying relevant references. FB and MEA contributed significant text. All authors, SM, CR, FB, and MEA, were in close collaboration and responsible for critical revisions of the manuscript. All authors read and approved the final manuscript.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

References

1. Ferlay J, Soerjomataram I, Dikshit R, Eser S, Mathers C, Rebelo M, Parkin DM, Forman D, Bray F (2015) Cancer incidence and mortality worldwide: sources, methods and major patterns in GLOBOCAN 2012. *Int J Cancer* 1(136):359–386. <https://doi.org/10.1002/ijc.29210>
2. Fadavi P, Motlagh A (2016) Strategies to improve cancer care, outcomes in Iran ASCO annual meeting. American Society of Clinical Oncology (ASCO), Illinois, <https://am.asco.org> Daily News
3. Page AE, Adler NE (2008) Cancer care for the whole patient: meeting psychosocial health needs. National Academies Press. doi: <https://doi.org/10.17226/11993>
4. Murray SA, Kendall M, Boyd K, Worth A, Benton TF (2004) Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers. *Palliat Med* 18(1):39–45. <https://doi.org/10.1191/0269216304pm837oa>
5. Puchalski CM (2008) Spirituality and the care of patients at the end-of-life: an essential component of care. *OMEGA* 56(1):33–46
6. Puchalski CM (2001) The role of spirituality in health care. Baylor University Medical Center Proceedings. Taylor & Francis
7. Ahmadi Faraz M, Sherbafchi MR, Mousavizadeh R, Raeesi N, Ghaderi S, Shirvani A (2016) Introduction to principles of spiritual care. Isfahan Medical Sciences University, Isfahan
8. Visser A, Garssen B, Vingerhoets A (2010) Spirituality and well-being in cancer patients: a review. *Psychooncology* 19(6):565–572
9. Ramezani M, Ahmadi F, Mohammadi E, Kazemnejad A (2014) Spiritual care in nursing: a concept analysis. *Int Nurs Rev* 61(2): 211–219. <https://doi.org/10.1111/inr.12099>
10. Fawcett J, Desanto-Madeya S (2012) Contemporary nursing knowledge: analysis and evaluation of nursing models and theories. F.A. Davis company, Philadelphia
11. O'brien ME (2013) Spirituality in nursing: standing on holy ground. Jones and Bartlett, Burlington
12. Tanyi RA (2002) Towards clarification of the meaning of spirituality. *J Adv Nurs* 39(5):500–509
13. True G, Phipps EJ, Braitman LE, Harralson T, Harris D, Tester W (2005) Treatment preferences and advance care planning at end of life: the role of ethnicity and spiritual coping in cancer patients. *Ann Behav Med* 30(2):174–179. https://doi.org/10.1207/s15324796abm3002_10
14. Balboni TA, Vanderwerker LC, Block SD, Paulk ME, Lathan CS, Peteet JR, Prigerson HG (2007) Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *J Clin Oncol* 25(2):555–560. <https://doi.org/10.1200/JCO.2006.07.9046>
15. Rahnama M, Fallahi Khoshknab M, Madah SSB, Ahmadi F (2015) Explaining the process of spiritual care in rehabilitation of cancer patients: a grounded theory study. *Medical-Surgical Nursing Journal (MSNJ)* 4(3):1–12
16. Tofighian T, Kooshki A, Borhani F, Rakhshani MH, Mohsenpour M (2017) Nursing students and nurses attitude toward spirituality and spiritual care. *Med History J* 8(29):45–62 journals.sbmu.ac.ir/en-mh/article/view/16750
17. Rahimi N, Nouhi E, Nakhaee N (2013) Spiritual well-being and attitude toward spirituality and spiritual care in nursing and mid-wifery students. *Iran J Nurs* 26(85):55–65 URL: <http://ijn.iuims.ac.ir/article-1-1690-en.html>
18. Zamanzadeh V, Rassouli M, Abbaszadeh A, Alavi-Majd HNA, Mirza-Ahmadi (2014) Spirituality in cancer care: a qualitative study. *J Qual Res Health Sci* 2(4):366–378 URL: <http://jqr.kmu.ac.ir/article-1-238-en.html>
19. Van Leeuwen R, Tiesinga LJ, Post D, Jochemsen H (2006) Spiritual care: implications for nurses' professional responsibility. *J Clin Nurs* 15(7):75–84. <https://doi.org/10.1111/j.1365-2702.006.01615.x>
20. Ross L (2006) Spiritual care in nursing: an overview of the research to date. *J Clin Nurs* 15(7):852–862. <https://doi.org/10.1111/j.1365-2702.006.01617.x>
21. Pearce MJ, Coan AD, Hemdon JE, Koenig HG, Abernethy AP (2012) Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. *Support Care Cancer* 20(10):2269–2276. <https://doi.org/10.1007/s00520-011-1335-1>
22. Balboni TA, Paulk ME, Balboni MJ, Phelps AC, Loggers ET, Wright AA, Block SD, Lewis EF, Peteet JR, Prigerson HG (2009) Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. *J Clin Oncol* 28(3):445–452. <https://doi.org/10.1200/JCO.2009.24.8005>
23. Edwards A, Pang N, Shiu V, Chan C (2010) The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: a meta-study of qualitative research. *Palliat Med* 24(8):753–770. <https://doi.org/10.1177/0269216310375860>
24. Narayanasamy A, Owens J (2001) A critical incident study of nurses' responses to the spiritual needs of their patients. *J Adv Nurs* 33(4):446–455
25. Keall R, Clayton JM, Butow P (2014) How do Australian palliative care nurses address existential and spiritual concerns? Facilitators, barriers and strategies. *J Clin Nurs* 23(21–22):3197–3205
26. Chan MF (2010) Factors affecting nursing staff in practising spiritual care. *J Clin Nurs* 19(15–16):2128–2136. <https://doi.org/10.1111/j.1365-2702.008.02690.x>
27. Wu LF, Lin LY (2011) Exploration of clinical nurses' perceptions of spirituality and spiritual care. *J Nurs Res* 19(4):250–256. <https://doi.org/10.1097/JNR.0b013e318236cf78>
28. Graneheim UH, Lundman B (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 24:105–112. <https://doi.org/10.1016/j.nedt.2003.10.001>
29. Guba EG (1981) Criteria for assessing the trustworthiness of naturalistic inquiries. *Educ Technol Res Dev* 29(2):75–91. <https://doi.org/10.1007/BF02766777>
30. Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, Chochinov H, Handzo G, Nelson-Becker H, Prince-Paul M, Pugliese K, Sulmasy D (2009) Improving the quality of spiritual care as a dimension of palliative care: the report of the consensus conference. *J Palliat Med* 12(10):885–904
31. Rassouli M, Zamanzadeh V, Ghahramanian A, Abbaszadeh A, Alavi-Majd H, Nikanfar A (2015) Experiences of patients with cancer and their nurses on the conditions of spiritual care and

- spiritual interventions in oncology units. *Iran J Nurs Midwifery Res* 20(1):25–33
32. Koenig HG (2014) The spiritual care team: enabling the practice of whole person medicine. *Religions* 5(4):1161–1174
33. Ozbasaran F, Ergul S, Temel AB, Gurol Aslan G, Coban A (2011) Turkish nurses' perceptions of spirituality and spiritual care. *J Clin Nurs Midwifery* 20(21–22):3102–3110. <https://doi.org/10.1111/j.365-2702.011.03778.x>
34. VandeCreek L (1997) Collaboration between nurses and chaplains for spiritual caregiving. *Semin Oncol Nurs* 13(4):279–280
35. Chan MF, Chung L, Lee AS, Wong WK, Lee G, Lau CY et al (2006) Investigating spiritual care perceptions and practice patterns in Hong Kong nurses: results of a cluster analysis. *Nurse Educ Today* 26(2):139–150. <https://doi.org/10.1016/j.nedt.2005.08.006>
36. Yong J, Kim J, Park J, Seo I, Swinton J (2011) Effects of a spirituality training program on the spiritual and psychosocial well-being of hospital middle manager nurses in Korea. *J Contin Educ Nurs* 42(6):280–288
37. Abbasi M, Shamsigooshki E, Abolghasemi MJ (2013) Introduction to spiritual health. Nashrhhoghoghi, Tehran
38. Ahmadi Faraz M (2016) Mediation through praying. Isfahan Medical Sciences University, Isfahan
39. Abbasi M (2013) Islamic approach to spiritual health. Nashrehoghoghi, Tehran
40. Tsai MT, Huang CC (2008) The relationship among ethical climate types, facets of job satisfaction, and the three components of organizational commitment: a study of nurses in Taiwan. *J Bus Ethics* 80(3):565–581
41. Koren ME, Papamitriou C (2013) Spirituality of staff nurses: application of modeling and role modeling theory. *Holist Nurs Pract* 27(1):37–44
42. Grant D, O'Neil K, Stephens L (2004) Spirituality in the workplace: new empirical directions in the study of the sacred. *Sociol Relig* 65(3):265–283
43. Dehghani K, Nasiriani K, Salimi T (2016) Requirements for nurse supervisor training: a qualitative content analysis. *Iran J Nurs Midwifery Res* 21(1):63–70
44. Pesut B (2002) The development of nursing students' spirituality and spiritual care-giving. *Nurse Educ Today* 22(2):128–135. <https://doi.org/10.1054/nedt.2001.0664>