



The requirements of hospital-based spiritual care for cancer patients

Maryam Moghimian¹ · Alireza Irajpour²

Received: 26 July 2018 / Accepted: 20 November 2018 / Published online: 24 November 2018
© Springer-Verlag GmbH Germany, part of Springer Nature 2018

Abstract

Purpose This paper aimed to discover the requirements of hospital-based spiritual care for cancer patients.

Methods This study was a descriptive qualitative-exploratory research, in which 25 participants were selected through purposive sampling and had semi-structured interviews.

Result The data analysis revealed 3 themes and 8 sub-themes including fundamental requirements (changes in the attitudes and behaviors of the healthcare team), structural requirements (inter-professional collaborations, a reference system), and functional requirements (religious-spiritual, pastoral, psycho-spiritual, and supportive-spiritual care). In this study, the received topics have been related to the spiritual care which can help improve patient care.

Conclusion The results were added to the repertoire of knowledge about the spiritual needs of cancer patients. The results indicated that it is essential to get acquainted with the spiritual care requirements in the hospital and enforce them through inter-professional collaboration. Accordingly, the spiritual care program should be designed, implemented, and evaluated.

Keywords Spirituality · Cancer care · Qualitative study · Hospital · Iran

Introduction

Development of diseases, in particular life-threatening such as cancers, is an important crisis in the life of any individual [1] and brings along spiritual challenges to meaning and goals of life [2]. The progressive state of disease in cancer causes patients to rely on spirituality as a powerful way to overcome these challenges and semantic conflicts [3]. Most of these patients see the sufferings and the pain as God's test, a chance to instill meaning in their lives and bolster the creativity in managing themselves [4]. Following their afflictions, patients tend to assess the milestones of their lives and frequently ask themselves the following questions: Does God exist? Does life have a meaning or a purpose? Will my disease injure

me? Am I dying? Is there a reliable person in these harrowing moments? [5] Spiritual care contains a wealth of answers to these questions which help patients accept their problems, feel relief [6], and adapt to their current condition [2].

Since cancer patients require frequent hospital admission, the healthcare team should discover the spiritual care needs of these patients in collaboration with the clerics and priests and plan a tailor-made care program for each patient [7]. Ross et al. proposed fulfillment of the patients' spiritual needs in the form of a spiritual care team consisting of physicians, nurses, religious counselors, and social workers [8] who could provide spiritual assistance during and after hospitalization [9]. The healthcare team should note that the spiritual needs of the patients are contingent upon the cultural, historical, and social backgrounds as well as their religious values [5].

Culturally speaking, Islam has been embraced by the majority of Iranians. This religion sees spirituality as the foundation of human perfection [10]. The most important part of spiritual needs relates to capturing the meaning of the human entity and communicating with God [11]. Quran strongly recommends collaboration among individuals to meet their needs and demands [12]. Accordingly, despite the need to paying attention to the spiritual needs of patients with cancer in the hospital, so far, there have been few studies to describe their spiritual care requirements in Iran.

✉ Maryam Moghimian
mmoghimian243@gmail.com

Alireza Irajpour
irajopur@nm.mui.ac.ir

¹ Nursing & Midwifery Sciences Development Research Center, Najafabad Branch, Islamic Azad University, Najafabad, Iran

² Social Determinants of Health Research Center, Critical Care Nursing Department, School of Nursing & Midwifery, Isfahan University of Medical Sciences, Isfahan, Iran

Part of a larger study, this research attempts to discover the spiritual care requirements of Iranian patients with cancer during hospitalization as reported through the comments of patients, their families, and the healthcare team.

Methods

Research design

This was a descriptive qualitative-exploratory study. Qualitative research suits the goal well when the researcher has to study and interpret the events as well as the participants' comments and viewpoints [13].

Research setting

The research setting covered internal oncology wards in a number of medical and non-medical centers as well as clinics, nursing homes, and the patients' houses in Isfahan, Iran. Isfahan is a strongly religious city with a 99% Muslim majority and a 1% religious minority of Christians, Jews, and Zoroastrians.

Participants and interview

Based on the research question, the researcher picked a heterogeneous sample with maximum diversity [13]. There were two groups of participants. The first group was those visiting hospitals to receive health services including the patients and their caregivers, while the second group consisted of the members of the healthcare team including nurses, physicians, psychologists, religious counselors, and social workers. The inclusion criteria were defined as follows:

The first group: patients over 20 years of age with different types of advanced cancer and disturbed personal, family, occupational, and social functions who expressed willingness to participate in the study. Concerning their caregivers, they should have aged 20 or older who wished and were prepared to be included in the study. The second group: the healthcare team with at least 3 years of experience in dealing with those patients who wished and were prepared to be included in the study.

The 25 participants had semi-structured interviews while one participant was interviewed twice. A single interview session lasted 40–60 min and all the conversations were recorded by an MP3 player. Interviews were started with an explanation and the main research question was “I have studied about your disease and I know what your physical problems are. Please tell me about your other problems, your needs and your expectations from the hospital staff during your hospitalization.” Based on the comments and the answers of the participants, more specialized questions were framed during follow-up

interviews. Data collection was performed from March to October 2016.

Ethical consideration The study was approved by the Ethics Committee of Isfahan University of Medical Sciences (No. 395255). Informed consent was obtained from all individual participants included in the study. The participants were assured they could withdraw from the research at any point. The names of the participants were kept confidential. Each participant was assigned a code to facilitate access to the interview scripts during analyses and reporting phases. Participants with negative and uneasy experience received mental supports.

Data analysis

Qualitative data analysis was conducted via Graneheim and Lundman method, through which data were categorized and named [14]. Following each interview, the first researcher would listen to the interview scripts twice and transcribe them verbatim. The results were summarized in the form of words and phrases to facilitate capturing the thrust of the interview sessions. Then, both researchers recited the summaries separately and categorized the meanings accordingly. The results of the analyses of both researchers were compared and contrasted and then used to draw conclusions. No new data emerged after conducting 26 interviews with 25 participants. Two complementary interviews were performed (with one patient and one nurse) to guarantee the data saturation at which no new data were generated.

For member-checking purposes, the results of the analyses were reviewed by two patients, one nurse, and one religious counselor who confirmed the researchers' interpretations. To conduct the peer check, these results were reviewed by eight researchers who were not involved in the research process, but specialized in the fields of spirituality, qualitative research, and cancer. The participants were chosen from different age ranges and educational backgrounds and for a variety of collaboration expectations to secure the data rigor and trustworthiness. To check the data transferability, the results of the analyses were reviewed by independent physicians and nurses (each two, a total of four) with experiences similar to those of the participants. A professional auditor was tasked with the external audition of data analysis.

Results

The study population consisted of 14 patients, 9 members of the healthcare team, and 2 caregivers. The patients had transitioned into the chronic, debilitating stage. The patients ($N=14$) were equal in terms of gender, 12 of whom were married and 2 were single. Ten patients were Muslims, 2 were Christians, 1 was a Jew, and the other was Zoroastrian. The

average job experience of the healthcare team who were all Muslims was 15 years. Table 1 presents the demographic characteristics of the participants.

A total of 17 interviews were conducted with the participants of the first group, and seven interviews were performed with members of the healthcare team. Eight sub-themes including changes in the attitudes and behaviors of health team, inter-professional collaborations, a reference system, religious, pastoral, psycho-spiritual, and supportive spiritual care for the spiritual needs of cancer patients were extracted from 750 codes and were assigned into three themes of fundamental requirements, structural requirements, and functional requirements. Table 2 presents the initial categories, sub-themes, and themes.

Category 1: the fundamental requirements of hospital-based spiritual care provision

The gist of the participants' comments and viewpoints indicated that hospital-based spiritual care provision requires a proper groundwork. The current policies and the dominant culture of hospitals need to change to allow for introducing the proper groundwork. The healthcare team attributed the poor hospital-based spiritual care services to inability in perceiving spiritual care and ambiguous characteristics of their duties (subcategory 1–1). Some members stated that they believed in spiritual care and wished to help patients in this regard, yet they had no clue about the provision of such care services (subcategory 1–2).

Category 2: the structural requirements of hospital-based spiritual care provision

The healthcare team believed that there was no agreement on the methods of spiritual care provision, the content of such care, and the functions of teams in this regard. The healthcare team sees spiritual care as an inter-professional collaboration where the specialists from a variety of fields could enhance their knowledge and skills of spiritual care via consultations and meetings (subcategory 2–1). According to the healthcare team members, since the

problems and complications of cancer patients affect all the dimensions of life, it is thus essential that all the members undertake a part of the spiritual care within their defined functions and refer them to a specialist after pinpointing the issue (subcategory 2–2).

Category 3: the functional requirements of hospital-based spiritual care provision

The comments and viewpoints of the participants suggested that comprehensive plans of the healthcare team should be accommodated to religious-spiritual, pastoral, psycho-spiritual, and supportive-spiritual needs of chronic patients. The interviews revealed that observing religious manners, performing religious practices, and resorting to religious values captured the collection of the religious needs of the patients. Fulfilling such demands places religious care provision on the agenda of treatment teams. Patients also believed that the perception of God's presence and receiving reassurances about the absolution of their sins would fill them with hope and enable them to cope with their challenges (subcategory 3–1). Pastoral care was thus necessary to fulfill the epistemological demands of the patients (subcategory 3–2). Most patients expected to be filled with hopes of recovering from their conditions and receive encouraging talks by their families and healthcare team. They preferred to spend time with their families and receive kind treatments to help them adapt to their current situation (subcategory 3–3).

Cancer patients highlighted the importance of consistent at-home supports and assistance to cope with their multiple problems. Citing expensive, diverse treatments, they also expected insurance companies, charities, and social working departments of hospitals to pay a share in alleviating the financial burdens and consequently the anxiety caused by their conditions (subcategory 3–4).

Discussion

This paper attempted to discover the requirements of hospital-based spiritual care for cancer patients. The results revealed three themes of fundamental requirements, structural requirements, and functional requirements for their spiritual needs.

Fundamental requirements involved changes in the attitudes and behaviors of the healthcare team. For these changes to happen, proper plans must be formulated. Most members of the healthcare team were not familiar with the importance and ways of spiritual care provision. Even if interested, they would start providing the care according to their set of beliefs and culture and with no formal training or following a standard-issue clinical guide. According to studies, it is possible to change the attitudes of care providers via promoting a proper

Table 1 The demographic characteristics of the participants

Married	Age range	Gender		Number	Participants
		Male	Female		
15%	22–79	50%	50%	14	Patient
100%	29–58	77%	23%	9	Health team
100%	40–53	50%	50%	2	Caregivers

Table 2 Categories, subcategories, and examples of participant quotations

Categories	Subcategories	Initial categories	Examples of participant quotations
1. The fundamental requirements of hospital-based spiritual care provision	1.1. Changes in the attitudes of the healthcare team	<ul style="list-style-type: none"> • Developing the culture of addressing the spiritual dimension of the patients • Creating awareness in the healthcare team about the spiritual care perspective 	“Even when most doctors see a patient is struggling with a spiritual issue, they say it is out of our scope of duties and powers. This needs the promulgation of a proper culture.” (An oncologist)
	1.2. Changes in the behaviors of the health team	<ul style="list-style-type: none"> • Enabling healthcare team for the provision of spiritual care • Access to the local guide of spiritual care • Funding the spiritual care services 	“Physicians tend to get less involved in these matters. Nurses do not see it as their task to work on the spiritual concerns of the patients. They do not refer the patients to us. Those who deal with the patients frequently should make them aware of the possibility of access to this kind of counseling. Unfortunately, they say it is not on the agenda of the hospital. They neither pay for it, nor have any training plan in place for this” (A religious counselor)
2. The structural requirements of hospital-based spiritual care provision	2.1. Inter-professional collaborations	<ul style="list-style-type: none"> • Embedding trained religious counselors in the healthcare team • Inter-professional assessments of the patients’ spiritual needs • Inter-professional planning for spiritual care provision • Inter-professional evaluations of the provided spiritual care services 	“If physicians, nurses, and psychologists do not pay attention to what is happening, the desired results will not take place; so all members should work as a unified team and focus on the patient’s problems to achieve a desired result (A nurse)
	2.2. A reference system	<ul style="list-style-type: none"> • Referring the patients to religious counselors for epistemological and religious interventions • Referring the patients to psychologists for specialized psychological interventions • Referring the patients to social workers for intervention in livelihood issues • Referring the patients to special care providers to address the related problems 	“What cancer patients want is to see that their existential problems are resolved. The intellectual concerns pester them and will not allow them to cope with their conditions. We just do not have to understand this and just do not focus on the physical aspects of the treatment. I think it is a must to employ the services of the specialists, so we could refer patients to them (a psychologist)
3. The functional requirements of hospital-based spiritual care provision	3.1. Religious spiritual care provision	<ul style="list-style-type: none"> • The patients’ need to observe religious manners • The patients’ need to resort to religious values • The patients’ need to perform religious practices 	“Patients are very tense. They keep saying how I can say my prayers now that I am hospitalized. How to pray? How can I expect God to help me out of this situation when even I cannot follow His orders. Care does not necessarily mean addressing oxygen demands or giving medications, etc. Maybe religious issues matter to them more (A nurse)”
	3.2. Pastoral care provision	<ul style="list-style-type: none"> • The patients’ need to perceive the meaning of life, death, and disease • The patients’ need to realize the existence of the Deity and receive His assistance • The patients’ need to reach eternity and access to the Divinity 	“I am always thinking why I am in such a state. I have suffered a lot in my life. I had a hard time make a living. I have never harmed anyone. Why me? Those who do big injustice to others are healthy and hearty. Is that God’s justice? I wish someone would relieve me of these thoughts (a patient with severe respiratory issues)
	3.3. Psycho-spiritual provision	<ul style="list-style-type: none"> • The patients’ need to attain tranquility • The patients’ need for sympathy and compassion • The patients’ need to accept their condition and adapt to it • The patients’ need to find sources of hope and inspiration 	“When I feel low, my kids rush me to the hospital. My wife keeps checking my oxygen gauge. They also help nurses while I am in hospital. Sometimes I feel that God has given them the power to inject me with new blood. They are so kind and respectful that I do not feel I am in a hospital. I do not feel unhappy at all in the hospital. I feel like home here (a patient with a metastatic cancer)
	3.4. Spiritual supportive care provision	<ul style="list-style-type: none"> • The patients’ need to receive support and assistance • The patients’ need to obtain information 	“My husband is pining away for the future of me and our children. I have to take care of my husband. The children go to school and I am the only one around. We just hope to beat frustration. It is a major concern

Table 2 (continued)

Categories	Subcategories	Initial categories	Examples of participant quotations
		• The patients' need to be respected	for such patients. He just keeps invoking God to help us (the wife of a cancer patient)"

spiritual care culture [15] and informing them about the significance of this kind of care [16]. In addition, enabling the staff and clarifying their functions by designing an indigenous spiritual care guideline could help facilitate offering such services [17]. The results of their studies suggested that dispelling the mental ambiguities could contribute to a sound perception of one's role in spiritual care and its provision, which is consistent with our findings. In this regard, the need to change the attitude and behavior of the healthcare team towards spiritual care will be the basis for further planning of this care.

Creating a structure for spiritual care provision is another requirement for hospital-based spiritual maintenance. Every participant emphasized the collaboration among the healthcare team to guarantee safe provision of spiritual care. The healthcare team should refer the patients to relevant specialists to resolve their spiritual issues. Every member of the healthcare team should play a part in designing a specific spiritual care program and initiate fulfilling their functions accordingly via consistent communication and consultation. Irajpour et al. found that pure focus on the symptoms would doom the performance of the treatment teams to failure. These teams should consult and communicate with each other on a regular basis through team working to cover all spiritual demands of patients. In addition, inter-professional collaboration should be considered in care policy-making [18]. Hospice and Palliative Nurses Association access to a committed care team whose members are in regular communication and consultation to respond to emerging spiritual issues of patients and their families is essential to the successful provision of spiritual care programs [19]. This is consistent with the findings of this research, emphasizing that the need for inter-professional collaboration and referral of patients to the relevant specialist is important in the structure of spiritual care.

In addition, the healthcare team should tailor the spiritual care programs of the patients to their religious-spiritual needs. Stronger religious beliefs highlighted the importance of religious, spiritual care during the debilitating stage of their diseases. Davidson et al. stated that Muslim participants demanded access to books and clean prayer notes and mats in hospitalization wards [20], which is consistent with the results of this study. Patients also tend to review their life experiences during the critical stages of their diseases to develop a foundation for interpretation and re-interpretation of their lives [21]. Contemplating the meanings of life and death

stimulates certain spiritual modes in patients and thus they are in dire need of care services to tackle these struggles [22]. To provide pastoral care, the authorities in Iran have assigned a religious counselor to every hospital across the country to help the patients with existential struggles. However, more has to be done.

Provision of psycho-spiritual care should also be considered in care programs. The patients expected physicians and nurses to start friendly conversations with them and give them sufficient explanations and guidelines to tackle and alleviate their concerns. The previous research has suggested that family, friends, and healthcare team could help patients attain a sense of "reassuring being" through the kindness and sympathy which could result in the development of a spiritual peace facilitating acceptance of problems and improving adaptive capabilities [23].

Further, the healthcare team should prepare individual care programs to fulfill supportive-spiritual demands of the patients. Follow-up treatment and continued assistance, consistent care services, showing respect, and developing awareness were suggested by patients as some examples of supportive care requirements. The patients facing altered roles and capabilities required more assistance. Although some care is provided in hospitals, the patients prefer to have a larger share of their care provided in their houses [24]. The results of this study and the current research confirm that the provision of spiritual care with its various dimensions should be incorporated in the care provision of cancer patients to be undertaken by the healthcare team.

Health policy-makers should note that meeting the spiritual demands of patients, i.e., provision of spiritual care, will enhance the adherence to treatment and health recommendations, provide the patients with spiritual health, instill hope in them [25], and modify their lifestyles to accommodate the treatment process [26]. Therefore, meeting the spiritual demands of patients requires an effective policy-making.

Conclusion

The findings suggested that the healthcare team should prepare individual care programs for patients. Achieving spiritual care objectives requires proper fundamental groundwork and determination of the structure of the healthcare teams and functions of the members.

Limitations

This study was conducted on citizens of Isfahan who are very sensitive to religious and cultural issues and maintain a special viewpoint about spirituality. Thus, the results may not completely reflect the spiritual demands of other cultures.

Acknowledgments The researchers sincerely acknowledge the efforts and contributions of the participants who attended the training centers in Isfahan, which are affiliated with Isfahan University of Medical Sciences.

Funding information This research was conducted with support of the deputy for researchers at Isfahan University of Medical Sciences (research proposal No. 395255).

Compliance with ethical standards

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

References

- Potter PA, Perry AG, Stockert P, Hall A (2016) *Fundamentals of nursing*. Elsevier Health Sciences, Netherlands
- Bekelman DB, Hutt E, Masoudi FA, Kutner JS, Rumsfeld JS (2008) Defining the role of palliative care in older adults with heart failure. *Int J Cardiol* 125(2):183–190
- Edwards A, Pang N, Shiu V, Chan C (2010) Review: the understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: a meta-study of qualitative research. *J Palliat Med* 24(8):753–770
- Cobb M, Puchalski CM, Rumbold B (2012) *Oxford textbook of spirituality in healthcare*. University Press, Oxford
- Taylor C, Lillis C, Lynn P (2015) *Fundamental of nursing: the art and science of person-centered nursing care*. Wolters Kluwer, Netherlands
- Hupcey JE, Penrod J, Fogg J (2009) Heart failure and palliative care: implications in practice. *J Palliat Med* 12(6):531–536
- Agrimson LB, Taft LB (2009) Spiritual crisis: a concept analysis. *J Adv Nurs* 65(2):454–461
- Ross L, Giske T, van Leeuwen R, Baldacchino D, McSherry W, Narayanasamy A, Jarvis P, Schep-Akerman A (2016) Factors contributing to student nurses'/midwives' perceived competency in spiritual care. *Nurse Educ Today* 36:445–451
- Koenig HG (2014) The spiritual care team: enabling the practice of whole person medicine. *Religions* 5(4):1161–1174
- Quran H (2008) Translated by Ayatollah Makarem Shirazi. Publication center of Quran of Islamic Republic of Iran, Tehran
- Cobb M, Dowrick C, Lloyd-Williams M (2012) What can we learn about the spiritual needs of palliative care patients from the research literature? *J Pain Symptom Manag* 43(6):1105–1119
- Irajpour A, Ghaljaei F, Alavi M (2015) Concept of collaboration from the Islamic perspective: the view points for health providers. *J Relig Health* 54:1800–1809
- Grove SK, Burns N, Gray JR (2014) *Understanding nursing research: building an evidence-based practice*. Elsevier Health Sciences, Netherlands
- Graneheim UH, Lundman B (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 24(2):105–112
- Cockell N, McSherry W (2012) Spiritual care in nursing: an overview of published international research. *J Nurs Manag* 20(8):958–969
- Phelps AC, Lauderdale KE, Alcorn S, Dillinger J, Balboni MT, Van Wert M et al (2012) Addressing spirituality within the care of patients at the end of life: perspectives of patients with advanced cancer, oncologists, and oncology nurses. *J Clin Oncol* 30(20):2538–2544
- 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* 12:885–904
- Irajpour A, Alavi M (2015) Health professionals' experiences and perceptions of challenges of interprofessional collaboration: socio-cultural influences of IPC. *Iran J Nurs Midwifery Res* 20(1):99–104
- Hospice, Association PN (2013) HPNA position statement: spiritual care. Retrieved August 30:2013
- Davidson JE, Boyer ML, Casey D, Matzel SC, Walden CD (2008) Gap analysis of cultural and religious needs of hospitalized patients. *Crit Care Nurs Q* 31(2):119–126
- Renz M, Mao MS, Omlin A, Bueche D, Cemy T, Strasser F (2015) Spiritual experiences of transcendence in patients with advanced cancer. *Am J Hosp Palliat Care* 32(2):178–188
- Groleau D, Whitley R, Lespérance F, Kirmayer LJ (2010) Spiritual reconfigurations of self after a myocardial infarction: influence of culture and place. *Health Place* 16(5):853–860
- Paukert AL, Phillips L, Cully JA, Loboprabhu SM, Lomax JW, Stanley MA (2009) Integration of religion into cognitive-behavioral therapy for geriatric anxiety and depression. *J Psychiatr Pract* 15(2):103–112
- Koszycki D, Raab K, Aldosary F, Bradwejn J (2010) A multifaith spiritually based intervention for generalized anxiety disorder: a pilot randomized trial. *Clin Psychol* 66(4):430–441
- Moghimian M, Irajpour A, Arzani HR (2018) The inter-professional dimensions of spiritual care for chronically ill patients: a qualitative study. *Nurs. Midwifery st In Press*
- Naghi JJ, Philip KJ, Phan A, Cleenewerck L, Schwarz ER (2012) The effects of spirituality and religion on outcomes in patients with chronic heart failure. *J Relig Health* 51(4):1124–1136