

# Evaluation of Health-Care Providers' Perception of Spiritual Care and the Obstacles to Its Implementation

Azam Shirinabadi Farahani<sup>1</sup>, Maryam Rassouli<sup>1</sup>, Nayereh Salmani<sup>2</sup>, Leila Khanali Mojen<sup>1</sup>, Moosa Sajjadi<sup>3</sup>, Mehdi Heidarzadeh<sup>4</sup>, Zeynab Masoudifar<sup>5</sup>, Fateme Khademi<sup>1</sup>

<sup>1</sup>Department of Pediatric and Neonatal Intensive Care Nursing, School of Nursing and Midwifery, <sup>5</sup>Oncology Ward, Mofid Children's Hospital, Shahid Beheshti University of Medical Sciences, Tehran, <sup>2</sup>Department of Meybod Nursing, Shahid Sadoughi University of Medical Sciences, Yazd, <sup>3</sup>Department of Medical-Surgical Nursing, Social Development and Health Promotion Research Center, Faculty of Nursing and Midwifery, Gonabad University of Medical Sciences, Gonabad, <sup>4</sup>Department of Critical Care Nursing, Nursing and Midwifery School, Ardabil University of Medical Sciences, Ardabil, Iran



**Corresponding author:** Maryam Rassouli, PhD, RN

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

Tel: 0098-021-88655372; Fax: 0098-021-88202521

E-mail: rassouli.m@gmail.com

Received: July 19, 2018, Accepted: October 07, 2018

## ABSTRACT

**Objective:** Cancer patients face many health challenges, including spiritual issues. Therefore, an awareness of health-care providers' perspective on spiritual care provision is important. This study aimed to determine health-care providers' perception of spiritual care and to examine the individual barriers to its implementation in cancer patients.

**Methods:** The present descriptive study included 136 physicians and nurses. The Spiritual Care Survey was used as a research tool. Data were analyzed through descriptive statistics using IBM SPSS Statistics for Windows, version 20.0. **Results:** In this study, 70.6% of the participants considered spiritual care to be influential in the patients' quality of life. However, 64.7%

had received no spiritual care training, while 82.4% indicated a willingness to attend these courses. Regarding the obstacles to providing spiritual care, the highest and lowest scores, respectively, belonged to the lack of time and the person's reluctance to talk about spiritual issues. **Conclusions:** Spiritual care has not yet found its proper place in the care setting of Iran, and health-care team members do not have sufficient training to provide this kind of care despite their belief in its positive impact on patients' quality of life.

**Key words:** Cancer patients, health-care providers, palliative care, spiritual care

### Access this article online

#### Quick Response Code:



**Website:** www.apjon.org

**DOI:**  
10.4103/apjon.apjon\_69\_18

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

**For reprints contact:** reprints@medknow.com

**Cite this article as:** Farahani AS, Rassouli M, Salmani N, Mojen LK, Sajjadi M, Heidarzadeh M, *et al.* Evaluation of Health-Care Providers' Perception of Spiritual Care and the Obstacles to Its Implementation. *Asia Pac J Oncol Nurs* 2019;6:122-9.

## Introduction

Diagnosing a life-threatening illness such as cancer is a stressful event that affects all aspects of a person's life.<sup>[1]</sup> Cancer is a major health concern in many parts of the world and the third main cause of mortality in Iran.<sup>[2-4]</sup> Every year, 30,000 deaths occur in Iran due to cancer, and 80,000 new cases are diagnosed annually.<sup>[5]</sup> The diagnosis of cancer can lead to the disruption of relationships, uncertainty about the future, difficulty in adaptation and coping, increased loneliness and doubts about spiritual beliefs and values, and spiritual distress.<sup>[6,7]</sup> Because of this, many cancer patients welcome spiritual assessment and spiritual care offered by health-care providers.<sup>[5]</sup>

Holistic care is mandated by the nursing and medical standards of care.<sup>[8]</sup> The World Health Organization (WHO) notes that the spiritual aspect of a patient is inseparable from the whole person.<sup>[9]</sup> The provision of spiritual care by health-care providers can lead to positive patient outcomes such as improved coping, well-being, quality of life, and hope as well as decreased anxiety regarding death, feelings of loneliness, depression, and a loss of meaning and purpose in life.<sup>[6,10-13]</sup>

However, the spiritual needs of patients with cancer are high, as reported by Forouzi *et al.*<sup>[14]</sup> Despite the fact that nurses are familiar with the importance of providing spiritual care, they are not able to comprehensively meet the spiritual needs of patients;<sup>[15]</sup> similarly, 96% of physicians believe in the important impact of spirituality on health, but these needs are not met<sup>[16]</sup> due to specific barriers, including nurse and physician perspectives and beliefs and values regarding spiritual care. Determining health-care providers' perspectives on spiritual care is the first step to facilitating the provision of such care.<sup>[17]</sup> It may also be helpful in the assessment of the patients' spiritual care needs and in designing spiritual care education and programs for health-care providers.<sup>[18]</sup>

Previous studies in different countries have identified obstacles to the provision of spiritual care;<sup>[19]</sup> it is also necessary to study these barriers in specific religious settings,<sup>[20,21]</sup> such as Iran, where spirituality and religion are linked together. In addition, it seems necessary to conduct such researches on nurses working in different wards as well. In Iran, the spiritual needs of patients may be neglected for various organizational reasons; these barriers for nurses include a lack of knowledge and skills,<sup>[21]</sup> a lack of executive instructions for spiritual care,<sup>[22]</sup> a willingness to perform routine work due to the large number of patients, lack of time,<sup>[23]</sup> and their inadequate training in this type of care.<sup>[24]</sup> However, according to the author's experiences and literature review, studies on individual barriers to spiritual care from the perspective of the nurses working in

wards where cancer patients receive care have rarely been conducted in Iran. However, spirituality, as an internal and individual force,<sup>[25]</sup> is an essential element in the lives of its people, which is rooted in the culture and history of this land.<sup>[13]</sup> Today, with the formation of palliative care along with the outlook of the strategic "Iran by 2025" health plan, which emphasizes the improvement of the mental-spiritual health of Iranians, religious and spiritual approaches are necessary as a personal concept to improve the health of patients and their families. Considering the importance of improving the quality of life of cancer patients and their health-care providers as a palliative care goal and to develop effective programs to help health-care givers provide cancer patients with quality care, the existing challenges need to be addressed.<sup>[26]</sup> The first step in facilitating the provision of spiritual care is to identify the health-care providers' perspectives; as the organizational obstacles to the implementation of spiritual care in Iran have been studied, leaving the challenges of individual barriers, the purpose of the present study was to determine health-care providers' perception of spiritual care and to examine the individual barriers to its implementation in cancer patients.

## Methods

### Research samples

The present research is a descriptive study. The research environment included all governmental hospitals affiliated with the medical universities nationwide and included surgical, internal medicine, pediatric, oncology, bone marrow transplantation, radiotherapy, and palliative care wards.

The research population included all health-care providers to cancer patients including physicians and nurses working in the abovementioned centers. The nurses and physicians were chosen using convenience sampling. To this end, Iran was first divided into the five regions of north, south, east, west, and center. Considering the research environment, a quota for each region was determined. The questionnaires were sent to 15 students pursuing master's and doctorate degrees. The participants comprised students of nursing at a large nursing and midwifery medical center in Iran who had received the necessary training in the field of spiritual care. These students distributed the questionnaires among nurses who were available and had at least 6 months of experience in the field of oncology nursing. The physicians taking this survey included all fellowship students and the residents of oncology, radiotherapy, pediatric, and internal medicine working at one of the abovementioned hospitals of the medical universities of the country. The purpose of this type of sampling was the widespread distribution of the questionnaires in different parts of the country

among physicians and the nurses working in internal medicine, pediatric, palliative care, oncology, bone marrow transplantation, and radiotherapy wards who were more frequently in contact with cancer patients.

In this descriptive study, 111 nurses and 25 physicians completed the Spiritual Care Survey in a 4-month period (from September to December 2017).

The approximate time required to complete each questionnaire was 20 min. The nurses and the physicians completed the questionnaire during their breaks or at home. They were supposed to complete the questionnaire in <2 work shifts.

### Research tool

The tool, which was based on the Multidimensional Measure of Religiosity and Spirituality, was derived from the Religion and Spirituality in the Cancer Care Study. In order to use this tool in the present research, some minor changes were applied into it by the research team.<sup>[27]</sup> The introduction of this tool includes the definitions of spiritual care and some examples of it. The participants in the study were asked to express their views on the various aspects of spiritual care based on a Likert scale.

Based on the research objectives, three parts of this tool were completed in the present study.

The first part included demographic data of the health-care providers as well as general questions regarding their general views of spiritual care based on variables such as age, gender, religion, work experience, ward, the percentage of patients with advanced cancer, whether they considered themselves religious or spiritual, the influence of religious and spiritual beliefs on clinical performance, the effect of providing spiritual care on patients' quality of life, training in spiritual care, and their willingness to take spiritual care training courses.

The second part of the questionnaire included eight items to assess health-care providers' perspectives on providing different types of spiritual care using a 6-point Likert scale. The lowest and the highest scores were 8 and 48, respectively.

The third part of the questionnaire included 13 items in a 4-point Likert scale, to examine the obstacles to providing spiritual care. The lowest score was 13, and the highest score was 52.

In order to use this tool, it was translated from English into Persian and retranslated into English in order to ensure that the English and Persian versions were identical.<sup>[28]</sup> Then, the psychometric evaluation of this scale was performed. To evaluate the validity of the scale after its translation and back translation, the content and face validities were evaluated. After studying the scale, 15 faculty members, experts in the field of spirituality, and

professionals in the field of psychology and instrumentation were asked for their comments and suggestions in terms of grammatical correctness and appropriate vocabulary to match the culture of the community. In addition, the perspectives of five research subjects were used to determine the level of difficulty of the phrases, the degree of mismatch, and the existence of any ambiguity. To evaluate the internal consistency and reliability, Cronbach's alpha was calculated. Cronbach's alpha of the health-care providers' perspective and that of the phrases related to the barriers to care provision was  $\alpha = 0.84$  and  $\alpha = 0.79$ , respectively. In order to evaluate consistency, the questionnaire was completed twice within a 2-week interval by 25 health-care providers and the intraclass correlation coefficient (ICC) was measured using the one-way random effect model between two sets of test results (ICC = 0.86, with a 95% confidence interval).

### Statistical analysis

The descriptive statistics were analyzed using IBM SPSS Statistics for Windows, version 20.0. (IBM Corp., Armonk, NY, USA) in order to answer the research questions.

### Ethical approval

In this study, the researchers obtained informed consent from the participants while explaining the goals of the study. For ethical compliance, the researchers assured the participants about the anonymity of the questionnaires and the confidentiality of the collected information. The present study is the result of a research project with the ethics code of IR.SBMU.PHNM.1395.5.

## Results

The majority of the research participants were women, including 82 (71.3%) nurses and 15 (60%) physicians. Many were Muslim (106 nurses [95.5%] and 23 physicians [92%]). Their demographic information is summarized in Table 1.

Overall, 66.2% of the participants (63.1% of the nurses and 52% of the physicians) regarded themselves as relatively religious and spiritual and 52.2% (54.1% of the nurses and 44% of the physicians) stated that their spiritual and religious beliefs affected their clinical performance. Moreover, 70.6% of all participants believed spiritual care as an impact on patients' quality of life. However, 64.7% (74 nurses and 14 physicians) of the participants had received no training on spiritual care, although 82.4% (83.8% of the nurses and 76% of the physicians) were willing to attend spiritual care training courses.

Health-care providers' perspectives on spiritual care are summarized in Table 2. The highest mean scores belonged to "asking patients about their spiritual or religious beliefs" ( $3.85 \pm 1.25$ ) and "asking questions that persuade

**Table 1: The distribution of some demographic characteristics of participants**

Variable	Frequency (%)		
	Nurses	Physicians	Total
Gender			
Female	82 (73.9)	15 (60)	97 (71.3)
Male	29 (26.1)	10 (40)	39 (28.7)
Presence of oncology ward			
Yes	99 (89.2)	14 (56)	113 (83.1)
No	12 (10.8)	11 (44)	23 (16.9)
Work experience (year)			
≤5	68 (61.3)	15 (60)	83 (61)
6-10	23 (20.7)	4 (16)	27 (19.9)
≥11	20 (18)	6 (24)	26 (19.1)
Employment ward			
Internal medicine	84 (75.7)	20 (80)	104 (76.5)
Pediatrics	25 (22.5)	4 (16)	29 (21.3)
Palliative care	1 (0.9)	0 (0)	1 (0.7)
Radiotherapy	1 (0.9)	1 (4)	2 (1.5)
Percentage of patients with advanced cancer			
0	8 (7.2)	3 (12)	11 (8.1)
≤10	16 (14.4)	5 (20)	21 (15.4)
11-40	38 (34.2)	4 (16)	42 (30.9)
41-70	35 (31.5)	12 (48)	47 (34.6)
>70	14 (12.6)	1 (4)	15 (11)
Religion			
Islam	106 (95.5)	23 (92)	129 (94.9)
Christianity	55 (4.5)	2 (8)	7 (5.1)

**Table 2: The health-care providers' perspective on spiritual care according to "Spiritual Care Survey"**

Items	Mean±SD
Asking patients about their religious or spiritual background to be aware of whether or not it is important to them	3.85±1.25
Encouraging patients in their spiritual activities or beliefs that are helpful to them	3.48±1.11
Asking questions that invite patients to talk about spiritual matters if they want to	3.71±1.38
For patients who are religious or spiritual, asking if there are ways their faith affects how they make decisions about treatment	3.16±1.32
For patients who may want to talk about spiritual matters, asking if they would like to speak with a chaplain (spiritual care provider)	2.94±1.06
If patients have religious or spiritual supports that are important, asking if they would like those spiritual supporters to be included in their care in some way	3.19±1.47
If a patient asks for prayer, the doctor or nurse praying with the patient	3.26±1.42
A religious/spiritual doctor or nurse offering prayer for a patient	3.67±1.71

SD: Standard deviation

them to talk about spiritual issues" ( $3.71 \pm 1.38$ ) and the lowest mean scores belonged to "asking patients about their willingness to speak with a clergyman" ( $2.94 \pm 1.06$ ).

Assessment of the barriers to providing spiritual care revealed the highest mean scores for "the lack of sufficient

time" ( $3.18 \pm 0.97$ ) and "being concerned about the patient's discomfort" ( $3.17 \pm 0.74$ ), while the lowest mean scores were for "personal reluctance to talk about spiritual issues with the patient" ( $2 \pm 0.95$ ) and "concern about disturbing the family's comfort" ( $2.22 \pm 0.89$ ) [Table 3].

## Discussion

Although providing spiritual care as a part of cancer care and palliative care instruction has benefits such as increased patient satisfaction; improved quality of life; and reduced costs of providing care, especially in the late stages of life,<sup>[21,27]</sup> studies show that this kind of care has been neglected<sup>[23]</sup> and that not only patients but also their care providers receive this kind of care less often than they desire. This gap between the willingness of care providers to provide spiritual care and the lack of provision of these services necessitates action.

As one of the requirements for providing spiritual care is an awareness of the care providers' perspectives on providing this care and the barriers to its implementation, the present study was conducted to address these issues.

In this study, the majority of participants evaluated themselves as relatively religious and spiritual and acknowledged that their spiritual perspectives influenced their clinical practice. When one sees his/her profession as a spiritual one, the ability to provide spiritual care also improves accordingly.<sup>[29]</sup> In one study, 89.4% of nurses considered nursing to be part of their spiritual lives.<sup>[30]</sup> Individual spirituality seeks to provide one with meaning and purpose in life through relationships and interactions with the environment and others. Therefore, spirituality will manifest itself in the workplace through relationships with others and with the environment.<sup>[31]</sup>

In the present study, care providers believed that spiritual care has positive effects and influences patients' quality of life, a finding that aligns with those of previous studies in Iran.<sup>[32-34]</sup> In this research too, care providers believed that spiritual care has positive effects and influences patients' quality of life. Religion and spirituality can affect one's ability to adapt to life tensions<sup>[35]</sup> and spiritual care improves the quality of life.<sup>[36]</sup>

A lack of spiritual care training was reported by most of the participants of the current study, although more than 75% indicated a willingness to attend training courses on spiritual care. In a study of care providers in 15 Middle Eastern countries regarding the need for palliative care, 68% of the participants expressed an interest in receiving palliative care training. As the mortality rate due to cancer in these countries is 66.4%, it seems natural that training to provide palliative care is a necessity for care providers.<sup>[37]</sup> Although spirituality and religion are merged in people's



**Table 3: Care providers' perception of barriers to providing spiritual care**

Barriers	Mean±SD
Not enough time	3.18±0.97
I am worried that patients will feel uncomfortable	3.17±0.74
I do not believe cancer patients want spiritual care from nurses/physicians	3.06±0.82
Lack of private space to discuss these matters with my patients	3.04±0.87
I worry that the power inequity between patient and nurse/physician makes spiritual care inappropriate	2.83±1.06
Religion/spirituality is not important to me personally	2.78±1.16
I have not received adequate training	2.67±0.96
I think it is inappropriate to engage these issues with patients who belong to a different religious/spiritual group than I do	2.6±0.85
I feel uncomfortable engaging these issues with patients whose religious/spiritual beliefs may differ from my own	2.5±1.04
I believe that spiritual care is better done by others in the health-care team	2.4±0.94
I do not believe it is my professional role to engage patient spirituality	2.32±1.14
I am worried that it will upset the patient's family dynamic	2.22±0.89
I am personally uncomfortable discussing spiritual issues	2±0.95

SD: Standard deviation

lives to a great extent in Iran,<sup>[26,38]</sup> they are neglected in practice, and there is no trace of spiritual care training courses in the medical education curriculum.<sup>[39]</sup> Meanwhile, education can be considered from two perspectives: first, it helps to promote the care providers' self-awareness of their spiritual life<sup>[40]</sup> and second, because of the direct correlation between spiritual training and the ability to provide spiritual care, spiritual training courses may lead to the improvement of this kind of care.<sup>[30]</sup>

As shown in Table 2, the findings of this study show that care providers' perspective regarding the field of spiritual care is diverse and mostly expressed in the form of actions such as asking patients about their spiritual or religious beliefs and if welcomed by patients and asking those questions that would persuade them to talk about spiritual issues. The review of texts suggests that spiritual care is provided in various forms, such as praying for patients, reading religious books,<sup>[41,42]</sup> inviting religious advisers,<sup>[43,44]</sup> participating in the religious rituals of patients,<sup>[44]</sup> encouraging the patient to pray,<sup>[43,45]</sup> and speaking about the spiritual concerns of patients.<sup>[43,45,46]</sup> Diversity in the provision of spiritual care stems from individual perspectives on spiritual care and the care providers' self-consciousness regarding their spiritual beliefs.<sup>[46]</sup> The participants in the study preferred to provide spiritual care mostly by speaking with the patient about his/her religious beliefs and encouraging discussions on spiritual issues, a finding similar to that in the qualitative study by Rassouli *et al.* They concluded that in the interaction between the nurse and the patient, the topic of communication is a factor that has positive effects on the spiritual aspects of both the patient and the nurse,

and that nurses who have effective relationships with their patient have a better opportunity to provide spiritual care.<sup>[13]</sup> Furthermore, Bailey *et al.* reported that more than half of the nurses stated that establishing a personal relationship with their patients is important in providing spiritual care and almost all of them believed that nurses could provide spiritual care by listening to patients and encouraging them to express their fears and anxieties.<sup>[47]</sup>

In the present study, the analysis of health-care providers' perceptions about different types of spiritual care revealed that patients are not usually asked about their willingness to interact with a clergyman. In the qualitative study by Zamanzadeh *et al.*, one perceived challenge described by nurses was the absence of clergyman in the hospital for the spiritual support of both patients and nurses.<sup>[48]</sup> Providing spiritual care to hospitalized patients is offered by clerics in some countries, which requires certification,<sup>[49]</sup> although their role is not defined in the health structure.

As shown in Table 3, evaluation of the barriers to providing spiritual care revealed that the study participants felt that a lack of time and a fear of patient discomfort were the major obstacles to effective spiritual care.

However, in a study conducted by Bar-Sela *et al.* of 770 physicians and nurses from 14 countries in the Middle East, a lack of adequate training was the most important predictor of the lack of spiritual care, while it was one of the least important factors in the current study.<sup>[28]</sup> The reason for this difference may be explained by the blending of religious and spiritual issues with the everyday lives of Iranians, the traces of which are evident in the politics, custom, law, and universities of the country. Therefore, care providers do not feel the need of receiving such specific training.

The barrier of inadequate time has been identified and confirmed in numerous studies.<sup>[50-53]</sup> The lack of sufficient time results in the spiritual needs of patients remaining unidentified<sup>[54]</sup> and insufficient time to provide spiritual care for patients.<sup>[55]</sup> In Iran, the shortage of nurses is one of the factors affecting the quality of care. The number of nurses is not appropriate to the number of patients, leading to nursing work overload and a lack of time to provide the different types of care required by patients. In such situations, nurses provide essential care,<sup>[56]</sup> such as physical care, prior to providing other types of care.<sup>[57]</sup>

A concern about patient discomfort was identified as the second barrier. Similar to this finding, other reported concerns which were identified as deterrents to the provision of spiritual care were lack of feeling of comfort in patients while providing spiritual care,<sup>[27]</sup> the fact that the spiritual needs of patients are considered private, and the way in which care team members enter this zone and deal with the spiritual needs of patients can lead to spiritual distress in patients.<sup>[58]</sup>

The unwillingness of health-care providers to discuss patients' spiritual issues and worry about bothering the patient's family dynamic by providing spiritual care to the patient were the barriers with the lowest scores.

Individuals' willingness to provide spiritual care is influenced by their self-knowledge; in other words, nurses with spiritual self-knowledge who pay attention to their own spiritual aspects deliver better care to others.<sup>[59]</sup> Therefore, the fact that the majority of the care providers completing this survey evaluated themselves as religious and spiritual people possessing some degree of spiritual self-scrutiny indicates a tendency to provide spiritual care; therefore, they do not consider these obstacles to be significant.

The concern about bothering the patient's family dynamic by providing spiritual care was another obstacle considered insignificant by the study participants. Nemati *et al.* reported spiritual distress due to losing hope in God's mercy and the feeling of being neglected by God to be a spiritual challenge faced by the family care providers of cancer patients. However, the other side of the coin is the feeling of spiritual coherence from providing care to cancer patients. Therefore, considering the general belief of health-care providers regarding the positive effects of spirituality, the concern about bothering the patient's family dynamic by providing spiritual care may be rarely considered an obstacle.<sup>[60]</sup>

## Limitations

The limitations of this study included the lack of palliative care departments, which specifically provide spiritual care in these wards; women's predominance as research samples; and the Muslim population with data collection from one site, which limit the generalizability of the findings.

## Conclusion

The results of the present study indicate that health-care providers regard themselves as spiritual and that spiritual care would improve the patients' quality of life. The lack of time and high workloads, however, are barriers to providing this care.

Moreover, health-care providers felt the need to receive specialized training in providing spiritual care, which rarely happens. Because spiritual care is effective in improving patients' quality of life, and as spiritual care provision is considered to be the responsibility of health-care providers, organizational and managerial support are essential in this regard. Providing adequate workforce, revising the strategies of governing care settings regarding the allocation of health-care providers' services, and designing and implementing theoretical and practical training courses

in the form of in-service training programs can help to overcome the existing problems and may be effective in promoting the provision of spiritual care.

## Proposal for further research

The perspectives of spiritual care providers who follow other religions should also be examined and compared with the results of the present study. As cancer care includes teamwork, spiritual care provided by team members other than physicians and nurses might also have an impact on patient outcomes and meeting of patients' spiritual needs. Further study is also necessary to evaluate the perspective regarding palliative care in team members other than physicians and nurses who have direct contact with cancer patients. This knowledge might help to promote administrative support for spiritual care in the oncology setting.

## Financial support and sponsorship

The authors would like to appreciate the deputy of research of Shahid Beheshti University of Medical Science for their support.

## Conflicts of interest

There are no conflicts of interest.

## References

1. Kim KS, Kwon SH. Comfort and quality of life of cancer patients. *Asian Nurs Res (Korean Soc Nurs Sci)* 2007;1:125-35.
2. Jemal A, Siegel R, Ward E, Hao Y, Xu J, Murray T, *et al.* Cancer statistics, 2008. *CA Cancer J Clin* 2008;58:71-96.
3. Siegel RL, Miller KD, Jemal A. Cancer statistics, 2015. *CA Cancer J Clin* 2015;65:5-29.
4. Üstündağ S, Zencirci AD. Factors affecting the quality of life of cancer patients undergoing chemotherapy: A questionnaire study. *Asia Pac J Oncol Nurs* 2015;2:17-25.
5. Hatamipour K, Rassouli M, Yaghmaie F, Zendedel K, Majd HA. Spiritual needs of cancer patients: A qualitative study. *Indian J Palliat Care* 2015;21:61-7.
6. Puchalski CM. Spirituality in the cancer trajectory. *Ann Oncol* 2012;23 Suppl 3:49-55.
7. Hatamipour K, Rassouli M, Yaghmaie F, Zendedel K, Majd HA. Development and psychometrics of a 'spiritual needs assessment scale of patients with cancer': A mixed exploratory study. *Int J Cancer Manage* 2018;11:e10083.
8. Skalla K, McCoy JP. Spiritual assessment of patients with cancer: The moral authority, vocational, aesthetic, social, and transcendent model. *Oncol Nurs Forum* 2006;33:745-51.
9. Seyed FN, Rezaei M, Givari A, Hosseini F. Prayer and spiritual well-being in cancer patients. *Payesh* 2006;4:295-303.
10. Livneh H, Antonak RF. Psychosocial adaptation to chronic illness and disability: A primer for counselors. *J Couns Dev* 2005;83:12-20.
11. Fisch MJ, Titzer ML, Kristeller JL, Shen J, Loehrer PJ, Jung SH, *et al.* Assessment of quality of life in outpatients with advanced cancer: The accuracy of clinician estimations and the relevance of spiritual well-being – A Hoosier Oncology

- Group Study. *J Clin Oncol* 2003;21:2754-9.
12. McClain-Jacobson C, Rosenfeld B, Kosinski A, Pessin H, Cimino JE, Breitbart W, *et al.* Belief in an afterlife, spiritual well-being and end-of-life despair in patients with advanced cancer. *Gen Hosp Psychiatry* 2004;26:484-6.
  13. Rassouli M, Zamanzadeh V, Ghahramanian A, Abbaszadeh A, Alavi-Majd H, Nikanfar A, *et al.* 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* 2015;20:25-33.
  14. Forouzi MA, Tirgari B, Safarizadeh MH, Jahani Y. Spiritual needs and quality of life of patients with cancer. *Indian J Palliat Care* 2017;23:437-44.
  15. Astrow AB, Wexler A, Texeira K, He MK, Sulmasy DP. Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? *J Clin Oncol* 2007;25:5753-7.
  16. Vahedian-Azimi A, Rahimi A. Concept of spirituality: A conventional content analysis. *J Q Res Health Sci* 2013;2:11-20.
  17. Ellis HK, Narayanasamy A. An investigation into the role of spirituality in nursing. *Br J Nurs* 2009;18:886-90.
  18. Stranahan S. Spiritual perception, attitudes about spiritual care, and spiritual care practices among nurse practitioners. *West J Nurs Res* 2001;23:90-104.
  19. Pesut B. The development of nursing students' spirituality and spiritual care-giving. *Nurse Educ Today* 2002;22:128-35.
  20. Memaryan N, Rassouli M, Nahardani SZ, Amiri P. Integration of spirituality in medical education in Iran: A qualitative exploration of requirements. *Evid Based Complement Alternat Med* 2015;2015:793085.
  21. Balboni MJ, Sullivan A, Amobi A, Phelps AC, Gorman DP, Zollfrank A, *et al.* Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. *J Clin Oncol* 2013;31:461-7.
  22. Curlin FA, Lantos JD, Roach CJ, Sellergren SA, Chin MH. Religious characteristics of U.S. physicians: A national survey. *J Gen Intern Med* 2005;20:629-34.
  23. Rushton L. What are the barriers to spiritual care in a hospital setting? *Br J Nurs* 2014;23:370-4.
  24. Adib-Hajbaghery M, Zehtabchi S, Fini IA. Iranian nurses' professional competence in spiritual care in 2014. *Nurs Ethics* 2017;24:462-73.
  25. Weathers E, McCarthy G, Coffey A. Concept analysis of spirituality: An evolutionary approach. *Nurs Forum* 2016;51:79-96.
  26. Rassouli M, Shirinabadi Farahani A, Khanali Mojen L. Palliative care perspectives and practices in the Islamic republic of Iran, and their implication on patients' quality of life. *Palliative Care: Perspectives, Practices and Impact on Quality of Life*. New York: Nova Scientific; 2017.
  27. Balboni MJ, Sullivan A, Enzinger AC, Epstein-Peterson ZD, Tseng YD, Mitchell C, *et al.* Nurse and physician barriers to spiritual care provision at the end of life. *J Pain Symptom Manage* 2014;48:400-10.
  28. Bar-Sela G, Schultz MJ, Elshamy K, Rassouli M, Ben-Arye E, Doumit M, *et al.* Training for awareness of one's own spirituality: A key factor in overcoming barriers to the provision of spiritual care to advanced cancer patients by doctors and nurses. *Palliat Support Care* 2018:1-8.
  29. Carroll B. A phenomenological exploration of the nature of spirituality and spiritual care. *Mortality* 2001;6:81-98.
  30. Chandramohan S, Bhagwan R. Spirituality and spiritual care in the context of nursing education in South Africa. *Curationis* 2015;38:1-15.
  31. Baldacchino D. Spirituality in the healthcare workplace. *Religions* 2017;8:260.
  32. Babamohamadi H, Ahmadpanah MS, Ghorbani R. Attitudes toward spirituality and spiritual care among Iranian nurses and nursing students: A cross-sectional study. *J Relig Health* 2018;57:1304-14.
  33. Fatemi MM, Nazari R, Safavi M, Naini MK, Savadpour MT. The relationships between nurses' spirituality and PATIENTS'SATISFACTION in the hospitals of Ardabil University of medical science. *Med Ethics J* 2016;5:141-59.
  34. Tofighian T, Kooshki A, Borhani F, Rakhshani MH, Mohsenpour M. Nursing students and nurses attitude toward spirituality and spiritual care. *Med History J (Quarterly)* 2017;8:45-62.
  35. Stuckey JC. Blessed assurance: The role of religion and spirituality in Alzheimer's disease caregiving and other significant life events. *J Aging Stud* 2001;15:69-84.
  36. Peteet JR, Balboni MJ. Spirituality and religion in oncology. *CA Cancer J Clin* 2013;63:280-9.
  37. Silbermann M, Fink RM, Min SJ, Mancuso MP, Brant J, Hajjar R, *et al.* Evaluating palliative care needs in Middle Eastern countries. *J Palliat Med* 2015;18:18-25.
  38. Rassouli M, Sajjadi M. Palliative Care to the Cancer Patient: The Middle East as a Model for Emerging Countries. In: Silbermann M, editor. illustrated ed: Nova Science Publishers, Incorporated; 2014
  39. Sadeghifar J, Bahadori M, Baldacchino D, Raadabadi M, Jafari M. Relationship between career motivation and perceived spiritual leadership in health professional educators: A correlational study in Iran. *Glob J Health Sci* 2013;6:145-54.
  40. Dunn LL, Handley MC, Dunkin JW. The provision of spiritual care by registered nurses on a maternal-infant unit. *J Holist Nurs* 2009;27:19-28.
  41. Callister LC, Bond AE, Matsumura G, Mangum S. Threading spirituality throughout nursing education. *Holist Nurs Pract* 2004;18:160-6.
  42. Büssing A, Koenig HG. Spiritual needs of patients with chronic diseases. *Religions* 2010;1:18-27.
  43. Carron R, Cumbie SA. Development of a conceptual nursing model for the implementation of spiritual care in adult primary healthcare settings by nurse practitioners. *J Am Assoc Nurse Pract* 2011;23:552-60.
  44. Fallahi Khoshknab M, Mazaheri M, Maddah SS, Rahgozar M. Validation and reliability test of Persian version of the spirituality and spiritual care rating scale (SSCRS). *J Clin Nurs* 2010;19:2939-41.
  45. Balducci L. Suffering and spirituality: Analysis of living experiences. *J Pain Symptom Manage* 2011;42:479-86.
  46. Chandramohan S, Bhagwan R. Utilization of spirituality and spiritual care in nursing practice in public hospitals in KwaZulu-Natal, South Africa. *Religions* 2016;7:23.
  47. Bailey ME, Moran S, Graham MM. Creating a spiritual tapestry: Nurses' experiences of delivering spiritual care to patients in an Irish hospice. *Int J Palliat Nurs* 2009;15:42-8.
  48. Zamanzadeh V, Rassouli M, Abbaszadeh A, Nikanfar AR, Alavi-Majd H, Mirza-Ahmadi F, *et al.* Spirituality in Cancer Care: A Qualitative Study. *J Q Res Health Sci* 2014;2:366-78.
  49. Saad M, de Medeiros R. Programs of religious/spiritual

- support in hospitals – Five “Whies” and five “Hows.” *Philos Ethics Humanit Med* 2016;11:5.
50. Curlin FA, Lawrence RE, Odell S, Chin MH, Lantos JD, Koenig HG, *et al.* Religion, spirituality, and medicine: Psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. *Am J Psychiatry* 2007;164:1825-31.
  51. Ronaldson S, Hayes L, Aggar C, Green J, Carey M. Spirituality and spiritual caring: Nurses' perspectives and practice in palliative and acute care environments. *J Clin Nurs* 2012;21:2126-35.
  52. Ramondetta LM, Sun C, Surbone A, Olver I, Ripamonti C, Konishi T, *et al.* Surprising results regarding MASCC members' beliefs about spiritual care. *Support Care Cancer* 2013;21:2991-8.
  53. McCauley J, Jenckes MW, Tarpley MJ, Koenig HG, Yanek LR, Becker DM, *et al.* Spiritual beliefs and barriers among managed care practitioners. *J Relig Health* 2005;44:137-46.
  54. McSherry W, McNidder R, Wordsworth H. Delivering spiritual care. Interview by Lynne Pearce. *Nurs Stand* 2009;23:22-3.
  55. Buswell J, Clegg A, Grant F, Grout G, Minardi HA, Morgan A, *et al.* Ask the experts: Spirituality in care. *Nurs Older People* 2006;18:14-5.
  56. Schubert M, Ausserhofer D, Desmedt M, Schwendimann R, Lesaffre E, Li B, *et al.* Levels and correlates of implicit rationing of nursing care in Swiss acute care hospitals – A cross sectional study. *Int J Nurs Stud* 2013;50:230-9.
  57. Ausserhofer D, Zander B, Busse R, Schubert M, De Geest S, Rafferty AM, *et al.* Prevalence, patterns and predictors of nursing care left undone in European hospitals: Results from the multicountry cross-sectional RN4CAST study. *BMJ Qual Saf* 2014;23:126-35.
  58. McEwen M. Spiritual nursing care: State of the art. *Holist Nurs Pract* 2005;19:161-8.
  59. Dezorzi LW, Crossetti Md GO. SPIRITUALITY IN SELF-CARE FOR INTENSIVE CARE NURSING PROFESSIONALS. *Rev Latino Am Enfermagem* 2008;16:212-7.
  60. Nemati S, Rassouli M, Ilkhani M, Baghestani AR. The spiritual challenges faced by family caregivers of patients with cancer: A qualitative study. *Holist Nurs Pract* 2017;31:110-7.