ORIGINAL ARTICLE

# Challenges in Providing Spiritual Care among Healthcare Workers: A Qualitative Study

**Hairulisa@Mohd Hairi NA[a], Wan Mamat WH[b], Mohamad Shariff N[b], Jaafar SNI[b], Che Ahmad A[c], Salah M[d]**

[a]KMI Kuantan Medical Centre, Pahang, Malaysia
[b]Kulliyyah of Nursing, International Islamic University Malaysia, Malaysia
[c]Kulliyyah of Medicine, International Islamic University Malaysia, Malaysia
[d]Qatar University, Doha, Qatar.

## ABSTRACT

**INTRODUCTION:** Spiritual care has been identified as an integral component of holistic, culturally competent, and empathetic care. Although spiritual care offers tremendous benefits for patients, it can be challenging to implement. Despite its importance, there is a lack of literature in Malaysia on the challenges that healthcare workers encounter in providing spiritual care. Therefore, this study aimed to explore healthcare workers' challenges in providing spiritual care to the hospitalised patients. **MATERIALS AND METHODS**: A qualitative study was conducted among healthcare workers at one hospital in Malaysia. A semi-structured interview was used to collect data from May 2023 until November 2023. All interviews were meticulously recorded, transcribed, and analysed using thematic analysis. **RESULTS:** Ten participants with diverse backgrounds willingly participated in the study. Analysis reveals a few challenges in providing spiritual care among healthcare workers such as time constraints, lack of knowledge, experience shortfalls, doubts about the efficacy of spiritual care, awareness deficiency among staff, and impact of patients' conditions. **CONCLUSION:** Healthcare workers are unable to fulfil patients' spiritual care for a variety of reasons. These findings have important implications for healthcare settings, highlighting the need for ongoing awareness and training in spiritual care competencies for healthcare workers.

**Keywords**
Spiritual care; healthcare workers; qualitative study

**Corresponding Author**
Dr. Wan Hasliza Wan Mamat
Kulliyyah of Nursing,
International Islamic University Malaysia,
25200 Kuantan, Pahang, Malaysia
Email: whasliza@iium.edu.my

Received: 25th April 2024; Accepted: 22nd August 2024

Doi: https://doi.org/10.31436/imjm.v24i01.2600

## INTRODUCTION

Spiritual care is an essential aspect of healthcare, provided by health professionals to prevent illness, treat conditions, and maintain overall well-being in patients.[1] Spiritual care implies that one tries to address patients' spiritual struggles, fears, and worries, listen to their spiritual needs, and support their underlying spirituality, whatever this may mean to them.[2] Puchalski[3] believed that exploring spiritual care such as what provides meaning to a patient's life and how they cope with illness can foster a more trusting and profound relationship. Studies have recognised that spiritual distress could occur at any time during the patient's journey, and good nurses should be adequately prepared to provide spiritual care whenever needed.[4] Kurniawati et al.[5] also revealed that patients attended by healthcare workers for spiritual care were motivated to be positive and took meaning in sick conditions to get a better life.

Spiritual care in medical settings encompasses a range of practices aimed at addressing the spiritual or religious needs of patients, which can significantly impact their overall well-being and satisfaction with their care. Despite its recognised importance, healthcare workers face numerous challenges when it comes to integrating spiritual care into clinical practice such as lack of staff, heavy workload of the

staff, heavy shifts, the non-standard nurse-to-patient ratio, lack of time, burnout,[6] fear of criticism from others, lack of education, space constraints, and absence of a recording system.[7] Understanding the perspectives of healthcare workers on these issues is crucial for developing strategies that enhance the capacity of clinical settings to provide meaningful spiritual care.

The theoretical framework for this study is based on the T.R.U.S.T. Model for Inclusive Spiritual Care, which is nonlinear, allowing spiritual exploration to begin in any of its five interconnected dimensions.[8] The first "T" stands for "traditions," focusing on how clients' past and present spiritual, religious, cultural, and healing traditions impact their well-being.[9] "R" represents "reconciliation," involving the exploration of unresolved issues to promote peacefulness and trust.[9] "U" stands for "understanding," addressing how an individual's worldview and personal beliefs influence their well-being.[9] "S" denotes "searching," which involves exploring existential or faith-based questions prompted by suffering.[9] The final "T" signifies "teachers," encompassing spiritual, religious, and personal mentors, as well as trusted resources that help individuals navigate relevant spiritual issues.[9] This model was designed to help healthcare professionals address the spiritual dimension of health as an integral part of holistic care.[10]

In the complex landscape of healthcare, the provision of spiritual care is a critical yet often overlooked component of holistic patient treatment. While a few hospitals in Malaysia have begun incorporating spiritual care into their services, this aspect is still in its nascent stages. Even healthcare workers seldom include spiritual care in their routine clinical practice.[11] Therefore, this study aimed to explore the challenges faced by healthcare workers' and their expectations in providing spiritual care to patients in the hospital setting. Healthcare workers, for the purpose of this paper, are defined as individuals who provide medical and nursing care, specifically including physicians and nurses.

## MATERIALS AND METHODS

### DESIGN AND SAMPLE

This study used a phenomenology design, a research approach that aims to describe the essence of a phenomenon by exploring it from the perspective of those who have experienced it,[12] or an individual's lived experiences within the world.[13] Participants were purposefully selected from one teaching hospital in East Coast Malaysia based on specific criteria: male/female, professional (nurse, physician), a minimum of six months' employment at the hospital, age 18 or older, and proficiency in either Malay or English. In a qualitative study, LoBiondo-Wood and Haber[14] agree and suggest that there is no fixed rule to establish the most appropriate sample size in qualitative research. The sampling continued until data saturation was reached, meaning the process was stopped once interviews ceased to yield new information or contribute additional codes for analysis.[15] A total of 10 participants were interviewed which had reached the level of data saturation.

### DATA COLLECTION

Participants were recruited between May 2023 and November 2023. Prior to the interviews, the researcher took time to build rapport with the participants. The interview was conducted to gain the participant's responses using a piloted interview guide. The data collection involved both informal and semi-structured face-to-face interviews. Example of the main questions: What are the main problems or challenges that you faced while delivering spiritual care to the patient? How do you encounter the

challenges? Explain the situation or event. Voice recorders were used with the participants' consent in addition to taking notes, ensuring comprehensive capture of the conversation for accurate transcription and subsequent data analysis. The interviews were lasted between 30 and 45 minutes and conveniently held in the offices of the participants.

## DATA ANALYSIS

Thematic analysis was applied to analyse the data. Thematic analysis is a technique that identifies themes within the data, with the themes forming the basis of categorisation.[16] This method entails a detailed examination of the data, in which the researcher meticulously codes the data to uncover meaningful themes. The codes and themes that are generated serve to integrate data gathered by different methods.[17] The first step involved a thorough transcription of the data from the notes and audio recordings. The researchers then scrutinised the transcripts, actively searching for significant meanings and patterns. The second step involved generating initial codes that represent the meanings and patterns in the data. This phase included discussions within the research team, composed of qualitative research experts, to identify pertinent text segments and assign appropriate codes. Similar meanings were aggregated under unified codes. The next step was to sift through these codes to identify potential themes, ensuring each theme was cohesive and relevant. Finally, the themes were defined and named. The reporting phase included a detailed presentation of the findings, enriched with examples for clarity. NVivo software facilitated the organisation of data into these defined themes, streamlining the reporting process.

## TRUSTWORTHINESS

Tobin and Begley[18] suggest that dependability and confirmability in research can be achieved by maintaining an audit trail. In this study, an audit trail was meticulously kept to record every step and any modifications made during the data collection, analysis, interpretation, and reporting phases. The researcher extensively recorded observations about the research process, interactions with participants, thoughts, emotions, and analytical interpretations in a research diary, which accompanied the audit trail. Additionally, engaging in discussions with the research team, comprised of experts in qualitative research, indirectly enhanced the study's rigour by providing critical insights and feedback, further ensuring the integrity and reliability of the research findings.

## RESULT

Ten participants consented to participate in this study, and their backgrounds are summarised in Table I. The analysis revealed six themes related to healthcare workers' challenges in providing spiritual care: 1) Time constraints, 2) Lack of knowledge, 3) Experience shortfalls, 4) Doubts about the effectiveness of spiritual care, 5) Awareness deficiency among staff, and 6) Impact of patients' conditions.

**Table I:** Socio-demographic characteristics of the participants

| | Participants (n) | |
|---|---|---|
| Age (years old) | 24-41 | |
| Gender | Male | 3 |
| | Female | 7 |
| Marital Status | Married | 9 |
| | Single | 1 |
| Position | Staff nurse | 3 |
| | Sister/Matron | 6 |
| | Doctor | 1 |
| Working experience (years) | 3-7 | |

### Theme 1: Time constraint

Most of the healthcare workers mentioned that time limitation is the main challenge for them as they have many tasks to settled within their work shift.

"Limitation of time is one of the challenges because sometimes patients with chronic illness have a lot to share with us, so it will take me time." (P5)

"We will always have other things to do, so each of us have limitations of time." (P8)

### Theme 2: Lack of knowledge

Few healthcare workers expressed their limitation of knowledge, which constrained them to deliver spiritual care to patients.

"Need to polish more…even though I am a spiritual trainer, I still feel that I do not have enough knowledge." (P5)

"Our knowledge is limited, sometimes we want to help patients, but we are not able to answer their questions, especially regarding religious practice. Some of it we will be able to answer, but there are also difficult ones." (P10)

### Theme 3: Experience shortfalls

New and young staff have been found to lack experience compared to senior staff and those who have been trained.

"But for new staff, they are still in the learning phase, they do not know things to do and could not reflect on patients' problems." (P3)

"I have less experience than the senior in this ward" (P6)

### Theme 4: Doubts the effectiveness of spiritual care

Healthcare workers find themselves uncertain about the effectiveness of their spiritual care practices due to the absence of a defined evaluation method.

"To ensure staff deliver suitable advice to patients, we don't know how effective is that." (P5)
"For me, we don't know the patients' acceptance about our spiritual care." (P6)

### Theme 5: Awareness deficiency among staff

Awareness among healthcare workers needs improvement. While some healthcare workers possess an understanding of spiritual care, there remains a significant reluctance among certain individuals to engage with it.

"Awareness…we could say still not enough, we need more awareness among staff" (P3)

"I think for staff awareness, especially in my ward, they should practice more." (P7)

### Theme 6: Impact of patients' conditions

Patients' age and critically ill patients matter as it affects healthcare workers' way of communicating with the patients. Patients' age matters, especially geriatric patients.

"For young patients it's manageable but for bedridden patients, it's quite difficult for us to deliver spiritual care" (P2)

"As you know in ICU, sometimes it's hard for us to deliver spiritual care due to patients' conditions" (P3).
"Older patients usually have their own attitude to be handled." (P6)

## DISCUSSION

Healthcare workers confront several common challenges in providing spiritual care, including limited time, insufficient knowledge, lack of experience, questioning the effectiveness of spiritual care, lack of staff awareness, and the impact of patients' conditions.

Time constraints are consistent in other studies, highlighting how healthcare workers struggle to allocate time for spiritual care amidst their numerous

responsibilities, often overlooking its importance in patient care.[19-21] Many healthcare workers recognise their limitations in knowledge, particularly regarding issues pertaining to religious practices, which they find challenging. This observation aligns with findings from other studies, which note the diversity of patients' needs that must be met became a barrier for them.[6,19,22] This study highlighted the issue of inexperience, noting that newer staff members often have less experience than their senior counterparts, leading to obstruction in delivering spiritual care to patients. This gap in experience aligns with the studies by Momeni et al.[6] and de Diego-Cordero et al.[11], where healthcare workers acknowledged their limited experience in providing spiritual care.

The study further revealed that a lack of awareness among staff poses a significant challenge for them in delivering spiritual care. Notably, not all healthcare workers acknowledge the significance of integrating spiritual care into patient treatment, resulting in its underutilization. The reluctance is reflected in the findings by Karimollahi et al.[23], who suggest that some healthcare workers perceive the provision of spiritual care as complicating their workflow. Moosavi et al.[24] reported that there is a sentiment among some staff members that engaging in conversations and listening to patients' spiritual needs is energy-draining and time-consuming. These challenges highlight the need for increased awareness and a deeper understanding of the value of spiritual care within the healthcare setting.

The condition of patients has emerged as another significant challenge for healthcare workers in providing spiritual care. Notably, delivering spiritual support to geriatric or critically ill individuals poses significant hurdles. Participant P3, for instance, shared the difficulties faced when attempting to offer spiritual care within the intensive care unit (ICU) setting, where many patients are terminally ill. Despite these obstacles, healthcare workers strive to address patients' spiritual needs to the best of their ability. Moreover, the study by Giske and Cone[4] emphasised that different age groups necessitate varied communication approaches by nurses, further complicating the delivery of spiritual care across patient demographics.

The new findings that can be highlighted in this paper are the uncertainty about the effectiveness of spiritual care has been a concern among healthcare workers, who expressed doubts about the impact of their spiritual care interventions. Without a clear method to measure effectiveness, healthcare workers felt it quite challenging for them to observe or acknowledge any changes in patient's conditions as an indicator of successful spiritual care. Therefore, the importance of ensuring that patients receive and comprehend the spiritual care provided is required for effective spiritual care practices in healthcare settings.

A notable limitation of this study is its reliance on participants from a single hospital. Despite the constraint, the in-depth data gathered through face-to-face interviews compensated for the study's limited scope, enriching the findings significantly. This research could be further extended to diversify the participant base by including healthcare workers from various types of hospitals across Malaysia. Future studies should encompass public, private, and other teaching hospitals, particularly those that adhere to shariah-compliant practices. Such an approach would enhance the representativeness and generalisability of the findings, providing a more comprehensive understanding of the challenges regarding spiritual care in diverse healthcare settings.

## CONCLUSION

The challenges healthcare workers encounter highlights the intricate nature of providing spiritual care to hospitalised patients. Nevertheless, the insights gleaned from these challenges offer a deeper understanding of the nuanced nature of spiritual care within healthcare environments. These findings carry significant implications for healthcare settings, underlining the critical need for continuous education, heightened awareness, and targeted training in spiritual care competencies for healthcare workers. By deepening their understanding of and respect for patients' spiritual beliefs and practices,

healthcare workers can navigate the challenges more effectively. This enables them to offer supportive spiritual care in tandem with medical treatment, facilitating a comprehensive approach to patient well-being. Such efforts are key to advancing the holistic health of patients, reflecting the essential role of spiritual care in the broader spectrum of healthcare.


## ACKNOWLEDGEMENT

We thank all participants for their involvement in this study. This research was supported by the Ministry of Education (MOE) through the Fundamental Research Grant Scheme (FRGS/1/2022/SKK07/UIAM/02/4)


## CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

## REFERENCES


1. Rushton, L. (2014). What are the barriers to spiritual care in a hospital setting?. British Journal of Nursing, 23(7), 370-374.
2. Büssing, A. (2021). The spiritual needs questionnaire in research and clinical application: A summary of findings. Journal of Religion and Health, 60(5), 3732 -3748.
3. Puchalski, C. M. (2001). The role of spirituality in health care. Baylor University Medical Center proceedings, 2001b, 352-357.
4. Giske, T., & Cone, P. H. (2015). Discerning the healing path - how nurses assist patient spirituality in diverse health care settings. Journal of clinical nursing, 24 (19-20), 2926–2935. https:// doi.org/10.1111/jocn.12907
5. Kurniawati, H., Retnowati, S., Riyono, B., & Widyawati, W. (2018). Literature review of spiritual care in Islamic cultural perspective. IBDA: Jurnal Kajian Islam Dan Budaya, 16(2), 350-368.
6. Momeni, G., Hashemi, M. S., & Hemati, Z. (2022). Barriers to providing spiritual care from a nurses' perspective: A content analysis study. Iranian Journal of Nursing and Midwifery Research, 27(6), 575-580.
7. Lee, G. E., & Kim, K. (2020). Analysis of spiritual care experiences of acute-care hospital nurses. Korean Journal of Hospice and Palliative Care, 23(2), 44.
8. Mcharo, S. K. (2018). T.R.U.S.T. Model for Inclusive Spiritual Care: Critique of Middle-Range Theory. Journal of Holistic Nursing. 36(3), 282-290. doi:10.1177/0898010117716854
9. Barss, K. S. (2012). TRUST: An affirming model for inclusive spiritual care. Journal of Holistic Nursing. 30 (1), 24-34.
10. Barss, K. S. (2012). Building bridges: an interpretive phenomenological analysis of nurse educators' clinical experience using the TRUST Model for inclusive spiritual care. International Journal of Nursing Education Scholarship. 2012, 9(1).
11. de Diego-Cordero, R., López-Gómez, L., Lucchetti, G., & Badanta, B. (2022). Spiritual care in critically ill patients during COVID-19 pandemic. Nursing Outlook, 70(1), 64-77.
12. Teherani, A., Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., Varpio, L. (2015). Choosing a qualitative research approach. Journal of Graduate Medical Education. 7, 669–670.
13. Neubauer, B. E,. Witkop, C. T., Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. Perspective on Medical Education. 8(2), 90-97.
14. LoBiondo-Wood, G., & Haber, J. (2014). Nursing research, methods and critical appraisal for evidence-based practice (8th ed.). St. Louis, MI: Mosby.
15. Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field methods, 18(1), 59-82.
16. Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. International Journal of Qualitative Methods, 5(1), 80-92. http:// www.ualberta.ca/~iiqm/backissues/5_1/pdf/ fereday.pdf
17. Bowen, G. A. (2009). Document Analysis as a Qualitative Research Method. Qualitative Research Journal, 9(2), 27–40. https://doi:10.3316/qrj0902027
18. Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. Journal of advanced nursing, 48(4), 388-396.
19. Burkhart, L., Bretschneider, A., Gerc, S., & Desmond,

M. E. (2019). Spiritual Care in Nursing Practice in Veteran Health Care. Global Qualitative Nursing Research, 6, 233339361984311. https://doi:10.1177/2333393619843110

20. Gavaza, P., Rawal, B. M., & Taylor, E. J. (2023). Pharmacy students' perceived barriers to spiritual care: A qualitative study. Exploratory Research in Clinical and Social Pharmacy, 9, 100246. https://doi.org/10.1016/j.rcsop.2023.100246
21. Schultz, M., Czamanski-Cohen, J., Bentur, N., Mohsen-Byadsi, S., Artsieli, Y., & Bar-Sela, G. (2020). Multidisciplinary staff perspectives on the integration of spiritual care in a new setting: Israel. Palliative & Supportive Care, 18(4), 431-436. https://doi.org/10.1017/S1478951519000877
22. Walker, A., & Breitsameter, C. (2017). The provision of spiritual care in hospices: A study in four hospices in North Rhine-Westphalia. Journal of Religion and Health, 56, 2237-2250.
23. Karimollahi, M., Abedi, H., & Yousefy, A. (2017). Self-Preservation in Both Sides: Pathology of Spiritual Care in Iran. Journal of Religion and Health, 56(1), 77–88.
24. Moosavi, S., Rohani, C., Borhani, F., & Akbari, M. E. (2019). Factors affecting spiritual care practices of oncology nurses: a qualitative study. Supportive Care in Cancer, 27(3), 901–909.