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Developing a charter of spiritual care for patients

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Abstract

Background: Spirituality is recognized as an important issue in health care, and every individual has spiritual needs. Despite increased knowledge about spiritual care and its necessity, there is no unique agreed-upon framework for spiritual care among the practitioners. This study aimed to explore the concept from the viewpoint of both health-care providers and patients within the Iranian social, cultural and overall contexts and present a charter for providing spiritual care.
Methods: The first phase of the study was a systematic literature review. The next phase consisted of two qualitative studies on the components of spiritual care from the perspective of healthcare providers and its dimensions as perceived by patients. The findings were then integrated to make up a charter draft that was accredited through expert opinion.
Results: The review of literatures led to the identification of two main themes and 10 themes. Perspectives of health-care providers were categorized into four main themes and 10 themes, and patients' opinions were classified into three main themes and 11 themes. The themes and their subthemes were integrated to build the concepts and form the proposed charter with 30 statements.
Conclusion: The charter of spiritual care for patients is intended to present an agreed-upon framework for spiritual care delivery and resolve some of the problems in this path. This can improve health-care delivery system.

Key words: charter, spiritual health, spiritual care, patients, health personnel, systematic review, qualitative research

Introduction

Through most of history, health care has been combined with spirituality and religious institutions have had an outstanding role in healing and treatment. Modern medicine neglected the spiritual component of health and focused on its scientific aspects [1], but in recent decades, spirituality began to restore and reclaim its previous position in health care and is being addressed increasingly. The concept of health has been enhanced in definition to include a spiritual dimension. Spiritual health with its universally accepted concept that focuses on meaning of life and transcendence [2] is regarded as a dimension of health permeating, deepening, shaping and unifying all aspects of human health [3, 4]. What is meant by spirituality may be different for every individual according to their worldview. All individuals have their spiritual needs, the provision of which helps them live better lives and have more effective interactions with their surrounding world [5]. So, spirituality has received much interest in health-care services, in that spiritual care has been considered as inseparable from physical, social and psychological care along with

which they form the whole [6]. A rapidly increasing body of literature shows that spiritual care is very important for both practitioners and patients and should not be ignored [7]. There are growing evidences on the contribution of spiritual care to patient experience, well-being and health outcomes [8–11]. Spiritual care has developed in recent decades and has been emphasized by the World Health Organization (WHO) [12], American Nurses Association [13] and American Holistic Nurse Association [14]. Correspondingly, increased attention has been paid to identifying best practice models for the provision and governance of spiritual care in health care [6, 15, 16]. Despite increased knowledge about spiritual care and its necessity [17–19], the problem lies in the implementation of research findings on spiritual care in clinical settings in which there are barriers to effective spiritual care including lack of time, insufficient knowledge and training, low motivation and diverse needs of patients [20, 21]. This is partly due to the fact that there is no agreement upon the concept of spiritual care and its components among practitioners and patients [22] within the context of health care. As a consequence, the care providers do not consider spiritual care as their duty. It seems that a charter can clarify the spiritual considerations that are expected to be addressed by health-care providers including doctors, nurses and midwives. The aim of the present study was to develop a charter of spiritual care for patients.

Methods

To have a comprehensive look at the issue of spiritual care and to utilize different experiences and the opinions of stakeholders and experts, the study was designed to include five phases:

1. A systematic literature review;
2. A qualitative study of the components of spiritual care from the perspectives of health-care providers;
3. A qualitative study of the patients' perception of spiritual care;
4. Integrating the findings of the previous phases;
5. Expert opinion.

Systematic literature review

This phase of the study aimed to integrate the findings of previous studies on spiritual care via a systematic literature review and descriptive thematic synthesis as proposed by Thomas and Harden [23]. We applied Lachal's tips on reading and coding the data in four steps: defining the research question and the selection criteria; assessing the quality of included studies; extracting and presenting the formal data and data analysis [24]. Five electronic databases including three international (MEDLINE, Scopus and Web of Sciences) and two national (Magiran and SID) were searched for full-text articles published during 2013–2018 in English and Persian. The search strategy was designed in order to retrieve the existing literature with the maximum recall and precision. The search strategy generated included the keywords: 'spiritual' or 'religious' or 'pastoral' or 'hospice' or 'palliative' combined with 'nursing' or 'care' or 'therapy' or 'treatment' or 'health'. Moreover, the words 'standard' or 'protocol' or 'charter' or 'guideline' or 'statement' or 'bill' accompanied with the words 'right' or 'need' or 'toolkit' or 'method' were added as the other search terms.

Regarding the inclusion criteria, full articles electronically available in English and Persian from 2013 to 2018 approaching the topic in the title were selected.

Out of the total 672 retrieved articles, 60 articles met the inclusion criteria and were included in the study. Each article was carefully read, coded and categorized, and analytical themes were generated, leading to two themes and 10 subthemes.

Qualitative study of the concept of spiritual care from the perspectives of health-care providers

This phase of the study aimed to explore the perspectives of health-care providers on the spiritual care concept and its components. To achieve this, a qualitative conventional content analysis study [25] was conducted with the participation of 11 health service providers (six nurses, three midwives and two physicians) selected by purposeful sampling in hospitals affiliated to Qom University of Medical Sciences. Participants were selected out of hospital employees with at least 5 years of experience in health care. To enrich the data with maximum diversity, the participants enrolled in the study had different backgrounds of age, gender and work experience in other cities and position.

Data were collected through in-depth semi-structured face-to-face interviews and field notes and analyzed simultaneously. The interviewers were two faculty members with acceptable experience in qualitative studies. The participants were provided with a brief description of the study and informed consent was obtained. Each interview began with the question: 'What does spiritual care mean to you?' and followed by exploratory questions each lasting 30–60 min. Interviews were recorded, transcribed, coded and categorized through a process of content analysis. The obtained data were analyzed simultaneously using the qualitative method of conventional content analysis in MaxQDA-10 software. Finally, the robustness of the data was confirmed by the participants and external controls.

Qualitative study of the patients' perception of spiritual care

The aim of this phase of the study was to explore the patients' perception of spiritual care. Participants consisted of 12 inpatients from Qom and Tehran university hospitals. Data collection and analysis in this phase was the same as the previous phase methodology. The interviewees were patients in different wards with diverse backgrounds and different physical states. The interviews were held in 30–60-min sessions, and the data analysis process was according to the conventional content analysis methodology [25].

Integrating the findings of the previous phases

The findings of the previous phases came from three different sources. Preparing a draft of the charter from these diverse sources required the integration of the themes and subthemes out of which the concepts were extracted. So, the findings of the abovementioned phases were gathered to form a pool of data. The data were purified through comparing and merging duplicated or similar concepts. Through a constant process of comparison and abstraction, a set of new or existing concepts were recognized that could form the foundation of the intended charter. The concepts then were composed in the form of statements and were categorized into two groups: the first focusing on the health-care providers' personal commitment and spiritual characteristics and the second regarding the patients' spiritual needs. This phase of the study was conducted by the research team and the output was a draft of spiritual care charter.

Table 1 Characteristics of the experts participating in the study

Education	Gender		
	Male *n* (%)	Female *n* (%)	Total *n* (%)
Nursing	3 (43)	4 (57)	7 (17.5)
Psychology	2 (50)	2 (50)	4 (10)
Theologians	3 (100)	0 (0)	3 (7.5)
Medical ethics	3 (100)	0 (0)	3 (7.5)
Traditional medicine	3 (100)	0 (0)	3 (7.5)
Endocrinology	2 (100)	0 (0)	2 (5)
Internal medicine	1 (50)	1 (50)	2 (5)
Oncology	2 (100)	0 (0)	2 (5)
Reproductive health	0 (0)	2 (100)	2 (5)
Health education and promotion	1 (50)	1 (50)	2 (5)
Community medicine	0 (0)	2 (100)	2 (5)
Medical education	1 (50)	1 (50)	2 (5)
Pediatrics	1 (100)	0 (0)	1 (2.5)
Anesthesiology	1 (100)	0 (0)	1 (2.5)
Pathology	1 (100)	0 (0)	1 (2.5)
Psychiatry	1 (100)	0 (0)	1 (2.5)
Neuroscience	1 (100)	0 (0)	1 (2.5)
Philosophy	1 (100)	0 (0)	1 (2.5)
Total	27 (67)	13 (33)	40 (100)

Expert opinion

To confirm the content of the charter developed in the fourth phase, the draft was offered to a number of experts who could provide constructive opinions to enrich the charter. To conduct this phase of the study, 60 experts in the field of spiritual health/care received in person or via email the charter draft accompanied by a checklist. The experts were allowed to write down their comments for each statement as well. The experts were selected based on the following criteria:

- Experience in spiritual care delivery for patients with cancer or chronic diseases, etc.
- Experience in national policy-making in the field of spiritual health/care.
- Membership in the spiritual health department of the Iranian Academy of Medical Sciences.
- Extensive research/publication in the field of spiritual health/care.

Forty experts responded from all over the country. The participants and their background characteristics are shown in Table 1.

The opinions expressed by the participants were studied carefully within five sessions of expert panel. The draft underwent some corrections and changes in a number of statements according to the experts' opinions and the proposed charter was concluded.

Results

Systematic literature review

The systematic review of literature led to the identification of two main themes and 10 themes as shown in Table 2.

Qualitative study of the concept of spiritual care from the perspectives of health-care providers

Health-care providers identified spiritual care in terms of four main themes and 10 themes as demonstrated in Table 3.

Table 2 Dimensions of spiritual care based on the systematic review of literature

Main themes	Themes
Spiritual care requirements	Patient spiritual assessment; Developing a structure for spiritual care delivery; Supporting and educating patient family; Supporting religious rituals;
Spiritual care process	Effective and supportive communication with patient; Patient education and responsiveness to him/her; Encouraging social communication maintenance and development; Encouraging patient happiness; Helping patient achieve peace; End-of-life care.

Table 3 Dimensions of spiritual care based on the health-care providers' perspectives

Observing the patient's rights	Respect, right to choose (choice) Preserving the patient's privacy Proper communication with the patient and his/her companion (relative)
Professionalism	Sense of responsibility Accepting the mistakes (errors) Development of technical skills and knowledge
Supportive behaviors	Paying attention to emotional and psychological needs
Strengthening the patient's religious dimension	Honoring religious beliefs Providing health care along with trust in God

Table 4 Dimensions of spiritual care based on the patients' perception

Religion-based care	Belief in God's presence Adherence to religious laws Spiritual environment Dignifying religious beliefs
Morality of care	Patient privacy Accountability Honesty and confidentiality Justice and fairness
Humanitarian care	Empathy Supportiveness Etiquette

Qualitative study of the patients' perception of spiritual care

Spiritual care as perceived by patients was explained through three main themes and 11 themes that are shown in Table 4.

Integrating the findings of the previous phases

The findings of the previous phases were analyzed and synthesized to make a draft of spiritual care charter. The draft consisted of 30 statements written in first person to make a self-declaration charter draft.

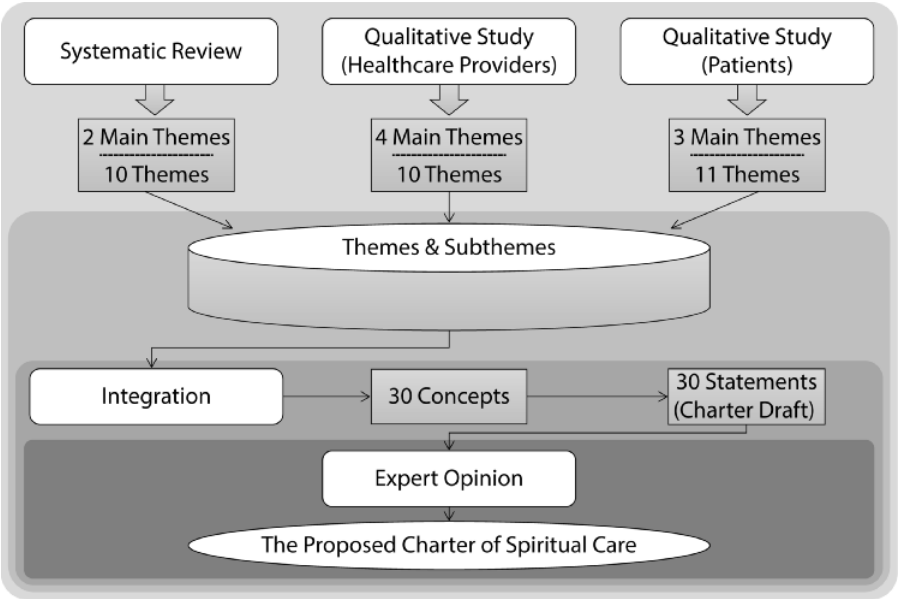

Figure 1. Summary of different phases of the study

A questionnaire was prepared based on the charter draft statements to gather the experts' opinions.

Expert opinion

Based on the expert opinion, the draft was revised. Eleven statements were approved without change, while 17 statements underwent a kind of revision with no considerable change in their meaning. Two statements were omitted as they overlapped with other statements and were substituted with other two statements emerged from the expert opinion.

The whole process of the study is illustrated in Figure 1.

Thus, the final number of the statements remained 30 as follows.

1. I perceive God's presence in every instance especially during patient care.
2. I believe that only God is the Healer, and I might have the chance to be a medium.
3. I am aware that my spiritual traits affect every service I provide.
4. I perform my duties by trusting the Almighty God and seeking His help.
5. I consider any patient a human being and the noblest creature of God.
6. I believe in the importance of serving patient and consider it as an opportunity for my transcendence.
7. I regard serving patient as an obligation and I am responsible and accountable to them.
8. I do my best to improve my competencies to provide spiritual care in a reliable manner.
9. I keep adherence to religious laws and rituals in providing care according to the patient's preferences.
10. I try to help patient achieve a sense of peace and tranquility through remembrance of God.
11. I pay special attention to the patient dignity in the care process.
12. I empathize with patient and treat him/her kindly.
13. I try to gain patient's trust all the time.
14. I respect patient's religious beliefs and requests.
15. I try to provide the appropriate conditions for patient to fulfill his/her religious rituals and practices.
16. I acknowledge and respect patient privacy.
17. I take permission from patient or his/her guardian prior to any service (except for emergencies).
18. I admit my error and try to compensate it in case of its occurrence.
19. I dedicate appropriate and adequate time for care delivery.
20. I always try to be available for patient whenever he/she needs my help.
21. I ignore the probable mistakes of patient.
22. I listen to the patient talks eagerly and give appropriate feedback.
23. I try to potentiate the patient constructive thoughts and resolve destructive temptations.
24. I try to improve patient hopefulness with special emphasis on relations with Almighty God.
25. I consult an expert in case of need to spiritual care beyond my competence.
26. I try to improve spiritual care delivery in my workplace.
27. I communicate and empathize to patient and his/her relatives.
28. I talk about death and beyond death to ease patient concerns, in case of his/her willingness.
29. I take into account the patient needs and desires in the end of life stage.
30. I participate in the religious rituals of the dying patient and the after death rituals.

Discussion

Statement of principal findings

This study aimed to develop a charter for spiritual care. A systematic literature review was designed to study the published articles in the field of spiritual care and explore the concept and its components. Since the concept of spiritual care is culture-dependent, and its components can be determined only in terms of the community in which it is going to be performed, two qualitative studies were

conducted with the aim of explaining the health-care providers' perspectives about spiritual care and the perceptions of patients on the issue. So, in addition to a rather comprehensive literature review, the ideas of both health-care providers and recipients in real conditions were taken and outlined in 30 statements, attempting to put it forth in a charter as a unified framework for spiritual health-care delivery.

Strengths and limitations

Since there is no explicit regulation on spiritual care as a responsibility/duty of health-care providers, this charter has clarified the general framework. However, there are specific needs in different settings for which specified guidelines should be prepared. Furthermore, there is no formal and structured education on spiritual care in Iranian medical education [26]; thus, the charter can be used in setting educational goals and designing curriculums and preparing the required continuous education contents. The charter could have effective consequences on the institutionalizing spiritual care in the health-care delivery system through increasing the sensitivity of the staff, informing them about holistic care and recognizing it as a part of their duties. The statements of the charter could be used to prepare a tool for the assessment of spiritual care status that can be performed both in the form of self-assessment and in the form of evaluation and accreditation processes by supervisors. The tools extracted from the charter could be used for research purposes, assessing the current situation of spiritual care and planning for its improvement. This charter has the potential to address staff motivation and to limit the medicalized approach to care [7].

A limitation of this study is that the viewpoints of the patients' families were not taken. Another limitation was that all the participants of the qualitative studies were Muslims and their ideas may not be in full accordance with other religious affiliations or nonreligious communities. Expansion of the study to include a larger number and more diverse groups for the qualitative study components can expand the charter and its generalizability.

Interpretation within the context of the wider literature

Charter is defined as 'a formal document describing the rights, aims, or principles of an organization or group of people' [27]. There are several charters in the field of health care. Patients' rights charters are the most widely known charters in health-care services, which have recently included patient responsibilities in addition to their rights [28]. Some charters have outlined patients' rights and responsibilities for specific diseases [29, 30], and a charter has addressed human values in health care [31] to name a few of charters compiled up to now.

Spiritual needs are part of the WHO definition of palliative care. The European Association for Palliative Care and National Consensus Project [32] have developed guideline for palliative care, and in these cases, spiritual care has been addressed within the field of palliative care, while it seems that the spiritual issues have not been addressed fully yet. To the best of our knowledge, there is no charter about spiritual care, and this can be the first effort in this field. On the other hand, research findings indicate that the concept of spiritual health is heavily dependent upon the underlying worldview of individuals and communities [33]. The worldview in its turn is influenced by values and norms determined by religious or cultural factors, giving rise to different definitions of spiritual health according to cultural backgrounds and diverse points of view [34, 35]. Integration of spirituality into health care will result in more compassionate, person-centered health systems [6, 36].

Despite the significance of spiritual care in palliative care [37], holistic care [38], critical situations [39] and end of life care [40], there is little actual spiritual care practiced in health-care delivery centers. It is argued that being engaged in spiritual care faces barriers including inadequate training and education [41] and lack of clear guidelines to practice it [42].

Given the differences in the concept of spiritual care in local, regional and international levels as a result of different cultural backgrounds, it seems necessary to reach an agreement and a unified model to be used, implemented and evaluated. At the same time, the charter can be modified to be used in different social, religious or ethnic communities.

Implications for policy practice and research

The charter for spiritual care can be helpful for policy-makers to take benefit in considering spiritual care as an essential component of holistic care; taking into account the spiritual care in the health-care providers' duties and evaluation criteria; integrating spiritual care in medical education programs and finally, adopting the appropriate policies to define spiritual care as a component of hospitals validation criteria.

As for its public implications, patients have different needs to be considered and responded by the health-care providers. Spiritual care is a main part of health care if it is intended to be regarded fully and has a main role in his/her recovery. Lack of a definite framework for spiritual care is a barrier of addressing this dimension of care. Issuing a charter for spiritual care can be helpful in increasing the sensitivity to this need of patients and improving the health-care quality.

Conclusion

Given the ever-increasing importance of spiritual care as a part of holistic care and the need for considering it in the health system policies, it is necessary to develop a shared framework. This study led to the development of the first charter of spiritual care for patients consisting of 30 statements. Since the charter is based on diverse sources of data including literature, patients' perceptions and health-care providers' perspectives, and expert opinions, it can be used to create more uniformity in providing spiritual care, remove some barriers of being engaged in spiritual care and improve the quality of health-care delivery. The proposed charter includes the general framework for spiritual care and thus is applicable in different situations. Moreover, it can be applied in education and provide a base for internal and external evaluation of health-care providers in spiritual care.

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Contributorship

All the authors contributed to the design of the study and the critical appraisal of the findings. A.H. supervised the project at all the stages of the study. M.A. and N.E. conducted the systematic review. H.A.T. and Z.K. were fully engaged in the qualitative studies. S.A. provided critical revision of the article. S.Y. was responsible for the integration

of the previous findings. A.H, S.Y. and M.H. prepared the draft of the manuscript. All the authors read the draft and finally approved the article to be published. All the authors are accountable for the accuracy and integrity of the work.

Data availability statement

Data are available and will be accessed on request.

Ethics and other permissions

To ensure ethical considerations in the qualitative interviews, the aims and procedure of the study were explained to the participants and informed consent was obtained for audio-taping the interviews. Each participant was given a code to ensure anonymity and confidentiality. The participants' dignity, privacy and freedom of actions were respected throughout the interviews. The study was approved by the Qom University of Medical Sciences Ethics Committee (IR.MUQ.REC.1396.63).

Conflict of Interest

The authors declare that they have no competing interests.

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