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Exploring the readiness of hospice and oncology unit staff to offer spiritual support to patients: preliminary findings

[Short title: Readiness of hospice and oncology staff to provide spiritual support]

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Abstract

Introduction: Patients' spiritual needs are often marginalized by medical staff, who identify them with religious practice, faith and God. Illness and related human suffering are not just physical ailments alone. The loss of health entails a number of changes in a patient's life and requires reorganization of the family, professional, social and spiritual aspects of it. The purpose of this article is to analyze the medical personnel's sense of readiness to provide spiritual care to patients of oncology units and hospice facilities.

Methods: The study was carried out with the use of Spiritual Supporter Scale whose psychometric values were determined on a high level of reliability with Cronbach's $\alpha = 0,88$.

Results: The results of the Spiritual Supporter Scale showed that oncology professionals got significantly lower scores (Me = 5; M = 5.11; SD = 1.89) in the overall scale score than those who work in hospices (Me = 7; M = 6.9; SD = 1.5). The analysis also showed that oncology unit employees (54%), declared that providing spiritual care to patients is an integral part of their work ($p < 0.02$) significantly less often than those employed in hospices (88%). They were also less likely to declare (77%) that spiritual support is necessary in their workplace than persons who provide care in hospices (95%; $p < 0.01$).

Conclusions: The study showed the differences in the sense of preparedness as well as competencies to provide spiritual care among medical workers in hospices and oncology units.

Keywords: spiritual care, hospice care, oncology patients, palliative care, psycho-oncology

Introduction

In the 1990s, Hiatt [1] proposed to extend the psychosomatic model of health and sickness, which was standard at the time, to include spiritual dimension. This stipulation resulted from many research observations, which pointed to the spiritual dimension being an important and inseparable element of behavior in health and sickness [2]. Despite the fact that spirituality in health care has already been defined in multiple ways, there is an overall consensus in the reference sources to usually understand it in a broader context than just religious experience because it is an existential construct with a more fundamental meaning [3]. One of the suggestions for defining spirituality, is framing it as "the way in which people understand and live their lives in view of their ultimate meaning and value" [4]. Current scientific theories highlight, more and more boldly, the categories of spirituality as one of the elements of the holistic concepts of human. Some ideas include not only mental and emotional intelligence but also a spiritual one as a foundation for all internal processes which

allow people to discover things and give them meaning which is so important for understanding and conscious experiencing of existential dilemmas [5].

According to the phenomenological concept of Schütz [6], illness changes one's perception of the world exponentially. From this perspective, it can be assumed that in the areas connected with receiving bad news, fear of death is a fundamental experience. The need to control "my world" is one of the elementary existential needs. The experience of an illness becomes a prism which, to various extents or sometimes fully, deconstructs previous meanings, experiences and social relationships (and sometimes even metaphysical experiences) or creates new ones in the light of new values. Therefore, besides the physical, psychological and sociological aspects, sicknesses involve a spiritual aspect. A plethora of research provides a lot of interesting information to confirm this view. They point to the fact that experiencing an illness can substantially change the existential perception in the area of the meaning of life as well as values [7, 8]. In this context, the spiritual dimension turns out to be an important element. It corelates with strategies of coping which, especially in the perspective of a life ending, become an area which determines life quality [9]. Spiritual aspects of existence stay strictly connected with the emotional sphere as well as cognitive functioning. In stressful situations, persons with a more coherent spiritual structure have access to a wider variety of coping strategies, which relates to a better psychological and physical health [10]. A positive correlation between spiritual sensitivity and a subjective sense of well-being was also pointed out [11]. Research revealed that a higher spiritual sensitivity is associated with a better adaptation to a chronic, somatic disease, optimistic predictions regarding its further course and a sense of a bigger influence on that course [12]. Moreover, a study conducted among oncology patients also showed a negative correlation between the level of depression or anxiety and the level of spiritual sensitivity [13].

Analyses conducted over the years have revealed that sensitivity to spiritual categories can be a significant factor in the realm of therapeutic influence, particularly in contexts related to facing illnesses with pessimistic prognoses [14]. For that reason, Anglo-Saxon countries started including programs into the structure of medical education, which develop competencies of health professionals in order to increase their sensitivity to spiritual aspects of diseases as well as patients' needs in this regard [15]. As persons who support oncology patients and their families, like nurses, doctors, psychologists, physiotherapists or capelans, play a special role, formal guidelines which provide recommendations concerning clinical practice were developed [16].

Though educational interventions to include the subject of spirituality in the area of medical education were successfully implemented in Anglo-Saxon countries, has not been so in Poland. According to available information, the only spiritual care course with particular emphasis on incurable diseases for medical students in Poland began at Collegium Medicum in Bydgoszcz of the Nicolaus Copernicus University in Toruń in 2018 [17]. It continuous to be taught as a mandatory subject till this day. Additionally, the Polish Association for Spiritual Care in Medicine, which was established in 2015, remains active. Despite areas regarding spiritual care of patients in Poland being noticed in the research space [18–21], there still remains a serious deficit of analyses concerning this aspect of intervention. That's why the aim of our research was to try to analyze the medical staffs' sense of being prepared to provide spiritual care to patients. It is a really significant problem because both medical staff and the patients notice the need for this type of intervention and point to its deficit [22, 23].

The aim of this study was the analysis of the medical staff's sense of being prepared for providing spiritual care to hospice and oncology patients. We wanted to find out if health professionals who provide active and direct care to hospice and oncology patients differ in terms of their readiness to provide spiritual care to their patients and their sense of this readiness as well as the self–assessment of their competencies in this area.

Methods

Study design

The cross-sectional study was conducted using a survey questionnaire technique. The research was executed with the help of a standardized Spiritual Supporter Scale, for which the psychometric values were defined at a high level of reliability with Cronbach's $\alpha = 0.88$ [24]. The questionnaire contains 31 closed questions based on multiple–choice answers in the form of the five-point Likert scale. The results in the scale's construction were structured into five subscales: Attitude to prayer, Beliefs regarding spirituality, Spirituality in relation to one's own suffering and the suffering of others, Sensitivity to the suffering of others, Attitude to community as well as the general score. The raw results were converted to Sten scores accordingly. Scores within Sten 1–2 were defined as very low, 3–4 as low, 5–6 as medium, 7–8 as high, and 9–10 as very high [24].

The research instrument additionally included six additional statements, which participants addressed using a five-point Likert scale. These statements pertained to

respondents' opinions regarding their readiness to provide patients with: preparation for spiritual support, the importance of spiritual care in caring for the patient and their family, the role of spiritual support as a professional task, and readiness to develop competencies in spiritual care. Multiple-choice responses of ‘strongly disagree’ and ‘disagree’, as well as ‘strongly agree’ and ‘agree’, were aggregated during the scoring analysis. The categorical variables in this study included: gender, profession, workplace, and religious affiliation.

Setting

The field stage of the study was conducted between the 12th December 2022 and the 26th April 2023 at the University Clinical Centre in Gdańsk, Polish Red Cross Marine Hospital in Gdynia, Saint Lawrence Hospice in Gdynia and Father Pio Hospice in Puck. After obtaining the necessary consents of the institutions’ administrators and chiefs of the units, we distributed the research questionnaires. Every physician, psychologist and nurse had an opportunity to take part in the study.

Participant identification

The conditions for inclusion in the study were: employment as a physician, nurse or psychologist and completing the whole questionnaire. 180 questionnaires were distributed. Saturation for this study was 43%. Ultimately, 75 people were included in the analysis. Four questionnaires were excluded: 3 of them were not filled out properly. One person declared being employed in both a hospice and an oncology ward, which did not allow to assign them to any group.

Ethics approval and consent to participate

The Independent Bioethics Committee issued a decision (KB/35/2024) to exempt this study from the requirement of Bioethics Committee approval. Before beginning the study, formal permissions for conducting the study were obtained from the heads of the departments and hospices where the research was performed. No sensitive data was being collected or processed during the study. Each respondent gave consent for taking part in the study.

Data analysis

The obtained data was subjected to statistical analysis with the use of Statistica v.13.3. The Shapiro–Wilk test was used in order to analyze the distribution. Student’s t-test was also used, as well as the U Mann–Whitney test for non-parametric variables, which enabled defining differences between groups and analyzing their statistical significance. To access

differences between groups in the independent questions, Pearson's chi-square test was used. The r-Pearson's linear correlation coefficient was also calculated in order to verify the existence of a correlation between age and the scale scores as well as between seniority and the scale scores. During the analysis, a statistical significance of $p < 0.05$ was assumed.

Results

Seventy-nine people took part in the study. Seventy-five people were included in the analysis, of which forty declared being hospice workers and thirty-five — oncology unit workers. There were 70 women and 5 men, including 53 nurses, 13 physicians and 9 psychologists between the ages of 22 and 63 (M = 43.64). Whitin that, 64 people declared a denomination, 5 stated they were atheists and 6 agnostics. The respondents' seniority varied from 1 year to 42 years (M = 19.64).

The score analysis of the Spiritual Supporter Scale [24] revealed that significant differences were observed between the two groups in the overall score ($p < 0.001$) as well as in 4 out of 5 subscales: Spirituality in relation to one's own suffering and the suffering of others ($p < 0.00$), Attitude to prayer ($p < 0.00$), Beliefs regarding spirituality ($p < 0.05$), Sensitivity to the suffering of others ($p < 0.02$). On average, in the overall score, respondents who worked in oncology wards got lower scores (Me = 5; M = 5.11; SD = 1.89) compared to those who worked in hospices (Me = 7; M = 6.9; SD = 1.50). Additionally, in each of the 4 subscales in which there were statistically significant differences, oncology unit employees had lower average scores than those who provided care in hospices (Table 1). The score analysis did not show linear correlation between the respondents' seniority or age and their scores in the Spiritual Supporter Scale (Table 2).

Both groups were given questions concerning their opinion on providing spiritual care with answers in the form of the five-point Likert scale. The answers strongly disagree and disagree as well as strongly agree and agree were grouped into two categories. Analysis showed that persons employed in oncology units (54%) declared that providing spiritual care to patients is an inseparable part of their job ($p < 0.02$) significantly less often than hospice staff (88%). Compared to the respondents who worked in hospices (95%; $p < 0.01$), they also were less likely (77%) to say that this type of support is necessary in their workplace. Groups of hospice (50%) and oncology unit (71%) health-care professionals expressed a similar level of disagreement with the claim that studies prepared them for providing spiritual care to

patients ($p = 0.21$). However, oncology employees (44%) declared lack of desire ($p < 0.03$) to develop competencies in this area (Table 3) significantly more often than hospice staff (13%).

Discussion

In this study, results obtained with the help of the Spiritual Supporter Scale point to a lower sense of being prepared for providing spiritual support among oncology unit health-care professionals in comparison to persons who work in hospices. It relates to both understanding one's own spirituality as well as attitude towards it in relation with a person in need of support and care [24]. What is more, oncology unit medical staff feel that providing spiritual care to patients and their families lies in their area of responsibility much less often. It might be that this view stems from slightly different foundations underlying the therapeutic impact.

We decided to compare results of the study with the ones obtained during the standardization of the Spiritual Supporter Scale [24]. The comparison revealed that the average score of the subscales: Spirituality in relation to one's own suffering and the suffering of others, Attitude to prayer, Sensitivity to the suffering of others as well as the scale's overall score coincided with the average score of our study's oncology staff group, which placed it at the average level on the Sten scale. However, in our study the hospice healthcare workers group got high scores on the Sten scale in all the subscales above. It might result from the fact that students of medicine, other medical fields as well as non–medical ones and teachers took part in the standardization of the tool. As students were the majority of the study's population, they might not have gained extensive experience regarding spiritual care in the medical field. Those types of competencies are also gained though incidental learning, especially in the area of end-of-life care. In the scale of Beliefs Regarding Spirituality, hospice staff got comparable scores to the study group in the standardization, whereas oncology employees obtained significantly lower ones. In the scale Attitude to community, both groups in our study got a similar score to the population analyzed in the questionnaire's standardization. As we summed up this portion of the results, it had to be noticed that the level of spiritual sensitivity of the health–care professionals we analyzed, turned out both low and lower than expected.

Most of the hospice (95%) and oncology unit (77%) employees who participated in the study admitted that providing spiritual care to patients they take care of is necessary in their workplace. Balboni et al. got similar results in their study. Over 80% of the oncology unit doctors and nurses who were asked, declared that spiritual care should be provided to

patients at least sporadically [22]. We got interesting results in the questions concerning the sense of being prepared for providing spiritual care to patients and one's own need to expand competencies in this area. Firstly, it should be noticed that hospice employees recognized that they were better prepared for providing spiritual care within their formal education than oncology unit employees. Despite that, health-care professionals who worked in oncology units declared the desire to develop their skills in providing spiritual care significantly less often (Table 3). It might be that this stance, as suggested Peteet and Balboni [25] in their research, results from the assumption that medical workers do not acknowledge providing spiritual care as an element of their professional duty. We think that it can be assumed, with some probability, that this stance results partly from understanding spiritual support as interference in the patients religious sphere.

Although our study delivers important observations, we realize it also has some objective limitations. In the presented preliminary research, there was an overrepresentation of women, who constituted 93% of the respondents. What is more, the overrepresentation of nurses (71%) in comparison to other medical professionals included in the study did not allow us to obtain a correlation of the respondents' profession with the questionnaire scores. The research tool used in the study, in the subscale Attitude to Prayer may, to some extent, lead respondents to identify spirituality with an element of religious practice. Associating spirituality with religiousness also had a significant influence on the saturation obtained in the study. We observed a significant churn rate — in the group of oncology unit employees withdrew from the study during the phase of questionnaire distribution. Many potential respondents refused to their part in the study due to their atheistic worldview as well as the reluctance to reveal their value system or their attitude towards God and religion. It seems to us that this aspect, although not directly analyzed in the study, is an interesting direction which outlines a possibility to extend the analyses to the understanding of spirituality by health-care workers.

Conclusions

Despite the growing amount of research, pointing to spiritual care as an important element of medical intervention, especially in areas concerning pessimistic prognoses and end-of-life, there are significant deficits in the domain of a sense of being prepared and a desire to provide spiritual care to patients among hospice and oncology unit medical workers.

Article information and declarations

We declare that we have not used or cooperated with Chat Generative Pre-trained Transformer (ChatGPT) technology or other artificial intelligence (AI) models in conducting the study, analyzing the data and preparing the manuscript.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author.

Ethics statement

The Independent Bioethics Committee issued a decision (KB/35/2024) to exempt this study from the requirement of review by bioethical committees.

Author contributions

ZG was responsible for preparing the study, completion of the field stage, statistical analysis of the results as well as preparing the first manuscript draft. KS was responsible for project oversight and result analysis. He also prepared the last manuscript version. ML took part in the field research and was responsible for proofreading and editing the article.

Conflict of interest

The authors declare that they have no competing interests.

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Supplementary material

None.

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Table 1. Analysis of inter-group differences in total score and individual scales of the Spiritual Supporter Scale

Scales	**Researched group**										
	Hospice workers (n = 40)					**Oncology unit workers (n = 35)**					
	Me	M	SD	Min	Max	Me	M	SD	Min	Max	p-value
Spirituality in relation to one's own suffering and the suffering of others	7	7.12	1.65	5	10	5	5.46	2.05	1	10	0.00*
Attitude to prayer	7	7.25	1.53	5	10	5	5.00	1.94	1	9	0.00*
Beliefs regarding spirituality	6	5.27	1.38	3	7	5	4.54	1.58	1	7	0.047*
Attitude to community	6	6.00	2.01	2	9	6	6.06	1.81	3	9	0.91
Sensitivity to the suffering of others	6	6.47	1.38	2	9	6	5.66	1.33	3	9	0.01*
Total score	7	6.9	1.50	5	10	5	5.11	1.89	1	10	0.00*

*Scores significant with $p < 0.05$

Table 2. Results of correlation analysis between seniority and age of respondents and individual scales and total score of the Spiritual Supporter Scale

Scale	**Seniority**	**Age of respondents**
	r	
Spirituality in relation to one's own suffering and the suffering of others	0.07	0.07
Attitude to prayer	0.29	0.35
Beliefs regarding spirituality	-0.00	0.05
Attitude to community	-0.15	-0.1
Sensitivity to the suffering of others	0.15	0.15
Total score	0.15	0.2

Table 3. Distribution of responses regarding statements about the preparedness and need for spiritual care for patients

Statements	**Strongly disagree and disagree**		**Strongly agree and agree**		**p-value**
	Hospice workers	Oncology unit workers	Hospice workers	Oncology unit workers	
My studies prepared me to provide spiritual care to patients	50%	71%	33%	17%	0.21
Providing spiritual care to patients is essential in my place of work	3%	14%	95%	77%	0.01*
Providing spiritual care to the patient's family is essential in my work place	3%	17%	93%	63%	0.00*
Providing spiritual care to patients is an integral part of my work	5%	29%	88%	54%	0.02*
Providing spiritual care to the patient's family is an integral part of my work	13%	33%	45%	41%	0.02*
I would like to develop my competencies in spiritual care.	13%	44%	45%	37%	0.02*

*Scores significant with $p < 0.05$