# Spiritual care training is needed for clinical and non-clinical staff to manage patients’ spiritual needs

## Abstract

### Purpose

As health-care moves towards a more person-centred approach, spiritual care has become more important in patients’ care. Recent evidence shows positive associations between both recognising and addressing patient spiritual needs and health outcomes. Thus, we conducted a cross-sectional survey to determine levels in understanding of patients’ spiritual needs and spiritual care among clinical and non-clinical staff working with people with chronic and terminal conditions.

### Methods

We administered an adapted version of the Royal College of Nursing online Spirituality and Spiritual Care Rating Scale (SSCRS) to hospital and community-care staff.

### Results

437 of 2845 eligible staff (15%) responded to the survey. Most participants agreed that spiritual care is fundamental to health care (n=322, 88%) and that care-giving organisations should provide support for dealing with patients’ spiritual needs (n=311, 85%). Dementia care staff encountered patient spiritual needs most often (p=0.0001) While participants recognised patients’ spiritual needs (mean-81%), only 51 (14%) stated they were always able to do so.

### Conclusions

We show that spiritual care training is needed for all staff having contact with people suffering chronic or terminal conditions. While respondents can identify definitions of spiritual needs, their ability to recognise associated behaviours and meet these needs is uncertain. The findings provide support for further studies to develop an evidence-based model of spiritual care training.

**Keywords**

Hospice care, Spiritual care, patient-centered care, needs assessment

## Introduction

Spirituality is becoming relevant to effective healthcare as it moves towards a more person-centred approach (Sterwart. et al. 1995). Growing evidence shows positive associations between spirituality and health outcomes (Salsman et al. 2015). Definitions of spirituality vary but it is suggested that it should not be confined to religion but situated within a broader definition (Speck. P 2004). Spirituality is currently described as a dynamic and intrinsic aspect of humanity through which persons seek meaning and purpose, as well as relationships to self, family, others, community, society, nature, and the significant or sacred (Roudsari, Allan, and Smith 2007).

Spirituality is expressed through beliefs, values and meaning (Puchalski and et al 2014). However, when a person becomes involved in therapeutic procedures, it is unfamiliar and often intimidating. During such times, patients, they have time to think about their lives, its meaning and the experience of a disease process. Here, factors associated with these circumstances may present as anxiety, pain, loneliness, and deprivation resulting in challenges to values and beliefs (Reimer-Kirkham et al. 2012). (Carpenito 2013). Thus, staff working with and around these patients must be aware of their spiritual needs (Narayanasamy et al. 2004).

Spiritual care is often assigned to the nursing profession. However, other areas of health care together with employees working in roles such as catering, and cleaning also have regular contact with patients. Thus, Swinton warns that while all professions may have something unique to offer, often only the opinions of the strongest voice take priority. Additionally, finding common agreement among staff is often difficult where the uniqueness of those needing spiritual care is neglected in the quest for unity (Swinton 2006). Koenig (2014) suggests that to provide whole person care, health professionals must be whole persons themselves (Koenig. H 2014). Thus, health professionals must have the emotional, physical, social and spiritual resources to carry out their work both individually and as part of a multidisciplinary approach. Spiritual care is also important to patients, particularly those nearing the end of life. Phelps et al (2012) found that patients, physicians and nurses showed strong agreement that routine spiritual care would benefit patients (Phelps and et al 2012). However, this study also showed that only a few patients reported receiving spiritual care.

Within nursing professions, Timmins and McSherry (2012) stress that spirituality is embedded within core values of nursing practice such as care, compassion and dignity. Here, McSherry & Jamieson (2011) also suggest that “nurses recognise that supporting patients with their spiritual needs has potential to enhance the quality of nursing care” (McSherry and Jamieson 2011). However, respondents felt more guidance and support from governing bodies was necessary to increase confidence in providing spiritual care. Indeed, previous findings also show insufficient management support, manpower and resources, as well as inadequate spiritual care practices (Cockell and McSherry 2012). From our pilot survey of 84 hospital health care employees we found that while staff could identify definitions of spiritual needs, their ability to both recognise and meet these needs are uncertain. We also found that few staff used valid spiritual data collection tools or talked with colleagues to identify patients’ spiritual needs (Austin et al. 2015 ). Thus, our objective was to replicate and extend the scope of the RCN online Spirituality Survey to determine the understanding of spirituality and spiritual care among clinical and non-clinical staff caring for people within palliative, rehabilitation and dementia care settings.

## Methods

### Participants

We conducted the survey in an organisation providing hospital inpatient rehabilitation, palliative and supportive care and mental health care for older people as well as an outpatient pain management service and community care in New South Wales, Australia. All clinical and non-clinical staff (n-2845) were eligible to participate in the survey. Areas of employment included health care staff (including managers) working both in the hospital inpatient and outpatient settings and within the community. We also invited clinical researchers, pharmacists and those working in cleaning, catering and patient transport to participate.

### Ethical approval

Ethical approval was given by the Human Research Ethics Committee of St Vincent’s Hospital, Sydney to distribute the adapted SSRCS to staff throughout HammondCare Health and Hospitals Limited. Concerning anonymity, participants only disclosed their gender, age-group, field of practice and their birthplace ethnicity where full confidentiality was observed.

### Data management

Data was collected via a secure online survey website and via internal mail. Data, was also stored as paper files in lockable cabinets while computer files were stored on computers with password protection.

### Survey instrument

We used the Royal College of Nursing (RCN) questionnaire that incorporated the Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry and Jamieson 2011). For this study, the SSCRS was adapted to represent the demographic of respondents working within a palliative and supportive care setting in Australia. Concerning ethnicity, we asked people to self-identify using categories utilised in the Australian Census. We categorised health care professionals using requirements of the Australian Health Practitioner Regulation Agency (e.g., nurses, physiotherapists and occupational therapists) and concerning physicians we followed guidelines stated by the Royal Australian College of Physicians. Additionally, specialist carers are specifically trained in palliative care but have no registrable nursing or medical qualification.

The SSCRS is a 17-item questionnaire that rates attitudes towards spirituality and spiritual care on a five-point Likert scale ranging from 5 (Strongly Agree) to 0 (Strongly Disagree). These items are structured around nine areas relating to spirituality including hope, meaning and purpose, forgiveness and spiritual care. The SSCRS also contains sections pertaining to spiritual care in practice and the role of respondents within an organisation setting. The SSCRS is reliable and valid across different populations and languages (Fallahi Khoshknab and et al 2010). The questionnaire was delivered electronically, while hard copies were distributed amongst staff with no organisation email accounts. The survey was developed using Survey Gizmo survey software.

### Data Analysis

All data were analysed using SPSS v.23 (SPSS Inc., Chicago, Il, USA). Data were analysed using descriptive statistics (frequency and percentage) to characterise participants taking part in this study. Kruskal Wallis one way analysis of variance test was used to compare survey answers to each item between different demographic groups (gender, religiosity, field of practice and age) as all data gathered were considered both nominal and ordinal.

## Results

### Participant demographics

Of the 2845 questionnaires distributed, 437 (15 %) were returned. Of these, 367 (13%) completed the full survey. Of the total returned, 352 (81%) were online and 85 (19%) were hard copies Most respondents were female (n=305 - 83%) and aged between 50-59 years (n-129, 35%) (Table 1). Most participants described themselves ethnically as Australian (n=270, 74%), followed by European (n=41, 11%) and South East Asian (n=23, 6%). Most staff stated their religion as Christian (n=274, 61%), while 224 (61%) stated they were practicing religion. Sixty-four respondents (18%) described themselves as having no religious affiliation. The largest groups of respondents according to job description were community care workers (n=98, 27%) and clinical nurse specialists (n=64, 17%). The largest groups of respondents by field of practice were dementia care (n=76, 21%), and support staff (n=74, 20%) (Table 2).

Table 1 Demographic characteristics of participants

**Table 2** Location of practice and work experience

### Levels of agreement toward provision of spiritual care

Strongest agreement lay with the respect from staff for privacy and beliefs of patients (n=352, 96 %), the showing of kindness (n-342, 93%), supporting and reassuring patients at times of need (n=341, 93%) and allowing patients time to discuss their fears (n=341, 93%). Staff also showed strong agreement for the provision of visits by the hospital Chaplain or the patient’s own religious leader (n=333, 91 %).

Staff practicing religion showed stronger agreement that spirituality is concerned with a need to forgive (p>0.0001), having a sense of hope (p>0.0001) and that spirituality is not concerned with a belief and faith in a God (p>0.0001) compared with non-practicing staff. There were also differences in agreement levels between fields of practice with palliative care staff reporting the strongest agreement that spiritual care involves listening and allowing patients time to explore fears and anxieties (p=0.009).

### Identifying patients’ spiritual needs

Most participants stated that they identified spiritual needs from listening to and observing patients, through the patient themselves, and by talking to loved-ones However, only 110 respondents (30%) stated that they would use a Chaplain while 66 (18%) stated they used spiritual assessment tools. Moreover, 40 respondents (11%) also stated it was not their role to identify patients’ spiritual needs (Figure 1)

Figure 1 How participants identify patients’ spiritual needs (% - n)

Identification of spiritual needs differed significantly between fields of practice. Those working in elderly mental health stated most they would ask patients’ relatives and friends whereas support staff did not (p=0.0008). Additionally, those working with the elderly stated most that they would also use health records (p=0.0002). Administrative workers stated while they had contact with patients it was not their role to identify spiritual needs (p>0.0001).

Thirty-one participants described using validated assessment tools. Twenty-four participants stated they used the HOPE assessment tool while three participants followed Fitchett’s assessment of spiritual needs. The FICA Spiritual Assessment Tool and the Palliative Care Outcome Collaboration assessment tools were each used by one participant. When asked how often participants encountered patients with spiritual needs, 34% said they did on a daily basis while a further 22% said they did on a weekly basis. Frequencies of encountering those with spiritual needs differed only between fields of practice where those working in dementia care settings encountered people with spiritual needs most often and support staff, the least often (p=0.0001).

### What are spiritual needs?

Participants showed strongest agreement with 'meaning and purpose' (90%) and 'hope and strength' (n=330, 90%) as spiritual needs. 'Creativity' as a spiritual need received the lowest agreement at 64% (n=235) (Figure 2). Only 33 participants (9%) added their own descriptions of spiritual needs with examples such as the need to feel connected, personal salvation, connection with nature and the need be heard and valued. There were no significant differences between subgroups regarding definitions of spiritual needs.

Figure 2 What participants consider as patients' spiritual needs (n-%)

### Who is responsible for spiritual care?

Most participants agreed (n=290, 79%) that all staff, regardless of job description, should be responsible for providing spiritual care (Figure 3). Participants also agreed that chaplains (n=261, 71%) and family and friends (n=253, 69%) should help to provide spiritual care. However, participants agreed less with the role of the patient providing their own spiritual care (i.e. being totally self-reliant in this area) (n=217, 59%).

**Figure 3** Who participants believe are responsible for providing spiritual care (n-%)

Concerning the responsibility for the provision of spiritual needs, there were significant differences between fields of practice where 33% more dementia care staff stated that all staff are responsible for providing spiritual care compared to older persons' mental health care staff (*p*=0.0001). There were no other significant differences between remaining subgroups.

### Ability to meet the patients' spiritual needs

Fifty-one participants (14%) stated they were always able to meet patients’ spiritual needs. Most participants (n=286, 78%) stated that they were able to sometimes, while 15 (4%) said they were never able to meet patients’ spiritual needs. While there were no significant differences between groups, those with more work experience felt they were able to meet patients’ spiritual needs more often (p=0.06). We included a follow-up question asking why participants thought they were not able to meet patients’ spiritual needs. Of the 55 (15%) of participants responding to this question, most stated they had no contact with patients, while others felt less able to meet patients’ spiritual needs due to a lack of time, limited knowledge, a lack of training and views that spiritual needs is best addressed by pastoral care staff.

### Actions required to improve spiritual care of patients

Most participants agreed that spiritual care and spirituality are fundamental to health care (n=322, 88%) and that organisations (care providers) should provide guidance and support for staff to deal with spiritual and religious issues (n=311, 85%). While there were differences in levels of agreement between those practicing and not practicing religion, combined levels of “agree” and “strongly agree” statements were similar (90%, 85% respectively). However, 65% of staff agree that they do not receive sufficient education and training in spiritual and religious beliefs (n=239). We found differences in agreement between groups on how to improve spiritual care of patients. However, when combining “strongly agree” and “agree” items and “strongly disagree” and disagree” items, there was only one area of significant disagreement. Here, we found that 261 (71%) of those practicing religion agreed that staff do not receive sufficient education in spiritual and religious beliefs compared to 198 (54%) of those not practicing religion (p-.001).

### Open comments

Participants (n=121) made additional comments about their understanding of spirituality and spiritual care. Most described the importance and the challenge in addressing patients’ spiritual needs and their own beliefs about what spiritual care involves. Many stated that spiritual care involves identifying what is most important to the person and not forcing one’s own beliefs on others stating further that spiritual and religious attitudes should not be mixed up. Concerning spiritual care guidelines and education, most participants suggested that spiritual care training should be broad to accommodate diverse needs relating to culture and background. Interestingly, one participant noted that spiritual needs of patients differ over time where those in residential care living with conditions such as dementia require creative and flexible understanding of how to support people at different stages of the illness.

## Discussion

### Support and Guidance

To our knowledge, this is the first study investigating the attitudes of both health care and non-health care workers towards spiritual care in hospital and community care giving settings. Our findings show that health care and support staff agree that spirituality and spiritual care are fundamental to health care. We also show that participants agree that hospital and care-giving organisations should provide guidance and support for dealing with patients’ spiritual and religious issues, regardless of job description. Additionally, many respondents felt that the combination of both a lack of knowledge and regular “hands-on” experience were their main limitations. These comments raise two important questions. First, in what areas of spiritual care are staff lacking knowledge and understanding? Second, given that many staff have infrequent contact with patients, how much, what type and more importantly, how often is training required? Spiritual care training has been shown to raise awareness and encourage discussion of aspects of spiritual care not just with patients and families but also within a care team (Paal, Helo, and Frick 2015). This latter point underpins why it is that both clinical and non-clinical staff need education and training in these matters.

### Ability to meet the patient’s spiritual needs

Participants stated excessive workloads, language barriers and a lack of patient-contact as reasons for not meeting patients’ spiritual needs. Others described a lack of confidence, feeling uncomfortable or a lack of understanding where they felt unable to communicate or where patients were unable to communicate their spiritual needs. Previous research shows barriers to the provision of spiritual care are a lack of time, knowledge and awareness, overcoming longstanding models of care and a reluctance to share personal beliefs (Edwards et al. 2010). Thus, it is important to determine who is best suited to meet patients’ spiritual needs where previously it may have been healthcare workers with similar worldviews and spiritual beliefs to their patients. For example, complementary needs or therapies such as literature and music compatible with patients’ worldviews should be considered by hospital staff.

### Assessment of spiritual needs

While talking to patients and loved-ones or listening and observing may help in familiarising oneself with patients , these forms of assessment are subjective and areas of value may be overlooked without a methodical assessment approach. In this present study only 8% of participants stated they used valid spiritual assessment tools. Studies recommend that structured assessment tools would address spiritual needs, improve documentation and show their effect on outcomes of treatment (Puchalski, Ferrell, Virani, and et al 2009). Interestingly, Rieg et al (2006) suggest a four-tier assessment of spiritual care based on standardised assessment of religious preferences, culturally defined spiritual practices, their spiritual interactions with available therapies and subsequent transformational interaction between spiritual knowledge and compassionate care (Rieg, Mason, and Preston 2006).

Furthermore, Rieg et al (2006) state that guidelines should facilitate competent spiritual care while also allowing care givers to recognise patients’ spiritual needs and, more importantly, that care givers become comfortable with questions that elicit spiritual assessment data (Rieg, Mason, and Preston 2006). However, given that non-health care staff also have contact with patients, we further suggest that administrative and support workers should undergo training to recognise key features of those in need of spiritual care.

### What are spiritual needs?

Participants recognised written examples of spiritual needs. However, few stated that they were able to deal with them in patients on a regular basis. We suggest this problem exists due to staff not having the ability to recognise behaviours that indicate spiritual needs. For example, 90% of participants agreed with the need for 'meaning and purpose', however they may not be aware of patients’ expressions of despair or emotional detachment from self or family that reflect these needs. Confusion between spiritual descriptors and behaviours may reduce the ability of staff to competently meet patients’ spiritual needs. Importantly, in an earlier study investigating the ability to recognise behavioural signs of spiritual needs, Highfield and Carson (1983) found that nurses recognised only five of 31 behaviours and of those five, four contained direct references to God or religion (Highfield and Cason 1983). These and our results raise important issues where limited abilities of staff to identify and address patient behaviour may ultimately affect diagnoses that include both the presenting problem and the underlying need of patients.

Keall et al (2014) investigated this issue using structured interviews with palliative-care nurses. Here, respondents underlined the importance of the nurse-patient relationship, communication skills and cues to “create openings” to facilitate care (Keall, Clayton, and Butow 2014). Their results also revealed barriers to spiritual care such as lack of required skills, privacy and the fear of uncovering unresolved symptoms. Importantly, participants offered strategies for further education, care-giver awareness and interdisciplinary sharing of information for continuity of care. However, further studies investigating patient expectations of nurse-care found that patients did not expect nor want spiritual care where they assumed that nursing involvement in spiritual care was referral to the chaplaincy (McSherry 2006).

### Who is responsible for spiritual care?

Views are divided with some studies advocating the role of the chaplain (Curlin and et al 2006) while others argue it is the responsibility of all those involved in care. Those who advocate the role of a chaplain may view spirituality within a religious context. However, there is growing consensus that spirituality is not necessarily located in a religious framework (Egan and et al 2011). In this present study, we found that most participants agreed that all staff (79%), regardless of job description, share the responsibility for providing spiritual care, while less (71%) believed chaplain staff were solely responsible. More surprisingly only 57% thought that health care staff were responsible for spiritual care. These findings differ from our previous hospital survey where participants stated that chaplains (79%), health care staff (87%) or all staff (67%) were most responsible for providing spiritual care (Austin et al. 2015 ). However, we found virtually no difference in attitude among different fields of practice with only those working in dementia care showing strongest agreement that all staff are responsible for spiritual care. Perhaps hospital chaplains and health care staff have greater visibility among both out and inpatients and their families. Alternatively, residents requiring community care have more contact with a range of support and community care workers. According to Hanzo and Koenig and more recently Puchalski and colleagues, all primary health care professionals have an important role to play in spiritual care (Handzo and Koenig 2004, Puchalski, Ferrell, Virani, Otis-Green, et al. 2009). However, the above studies do suggest specific roles for different professions. For example, Hanzo and Koenig propose that the role of the physician is to ensure the patient’s spirituality is assessed thoroughly while the role of the chaplain is to evaluate the patient in depth and provide spiritual support as appropriate (Handzo and Koenig 2004). Thus Puchalski and colleagues in their consensus report for the improvement in spiritual care state that all health care professionals should be trained in the beliefs of different faiths and different cultures in order to provide competent care. These recommendations and our results are also consistent with McSherry’s and Rumbold’s studies (McSherry and Jamieson 2011, Rumbold 2003) showing participants feel that spiritual care should not be monopolised by one area of health care but shared by the whole care team.

### What next?

Overall, current literature indicates that spiritual care training is required for health care staff who have contact with patients (Cetinkaya, Dundar, and Azak 2013). However, while efforts have been made to integrate spirituality into nursing and clinician curricula, data show that training is limited for nurses, increasing amongst physicians (Balboni et al. 2013), but non-existent among support, administrative and ancillary staff. It also appears that training remains voluntary (Rasinski and et al 2011). We recommend that spiritual care training is required for all staff regardless of job description. We also recommend that this survey should be replicated with patients within the same organisation in order to compare findings. Thus patient attitudes would help shape future development in practice, education and ongoing research.

We also recommend the further development of evidence-based models of spiritual care training. Recently, Morgan et al (2015) developed an educational program aimed at improving palliative care staff’s understanding of spirituality and spiritual care. This is a multi-disciplinary and collaborative learning programme addressing the learning needs of the whole team. Importantly, in keeping with the recommendations of others (Puchalski and et al 2014), the diversity of this course allows the consideration of the unique culture and spirituality of each individual (Morgan et al. 2015).

### Limitations

The response rate of 15% for our study was low. While response rates among community care workers and physicians were moderate, they were particularly low amongst registered nurses where only 13% responded to the survey. Therefore attitudes shown by nurses participating in the survey may not be representative of those working throughout the organisation. Given this discrepancy, and the contact nurses have with patients, emphasis must be given to the recruitment of nursing staff for future studies. Additionally, many support staff had no internet access to either have knowledge of the survey or to complete it. While we requested managers to distribute paper surveys and to encourage participation, direct communication with these staff would have been preferred.

## Conclusions

Our findings show that spiritual care training is needed for clinical and non-clinical staff working with people suffering chronic or terminal conditions. While staff can identify definitions of spiritual needs, their ability to recognise associated behaviours and meet spiritual needs in their patients is uncertain. The findings provide support for further studies to develop an evidence-based model of spiritual care training that considers a) the unique culture and spirituality of individual needing care, b) levels of understanding concerning different types of employment and c) the use of valid spiritual assessment tools.

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