Improving training in spiritual care: a qualitative study exploring patient perceptions of professional educational requirements

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Healthcare professionals express difficulties in delivering spiritual care, despite it being a core component of palliative care national policies. The patient perspective on professional training to address difficulties has not previously been sought. The aim of this study is to describe patient suggestions for development of training to deliver spiritual care. Qualitative semi-structured in-depth ‘palliative patient’ interviews (n = 20) were analysed thematically. Training suggestions encompassed practical care delivery. Patients supported staff who introduced questions about spiritual needs, and they expected opportunities to engage in spiritual care discussions. The ‘right’ attitude for spiritual care delivery was defined as being non-judgemental, providing integrated care and showing interest in individuals. Training issues included patient perspectives of boundaries between personal and professional roles. This study provides ‘palliative patient’ perspectives to strengthen recommended models of spiritual care delivery. It shows that user opinions on training can be helpful not only in deciding objectives but also how to achieve them.

Key words: continuing education; delivery of health care; needs assessment; palliative care; qualitative; spirituality

Introduction

Spiritual care is integral to palliative care, and meeting spiritual needs appears to improve the ability to cope with ill health. Although spirituality, spiritual care and spiritual needs have been difficult to define, key elements are likely to include exploring a sense of meaning and purpose in life. Despite the recognised importance to patients, there are difficulties encountered in delivering optimal spiritual care: first, uncertainty about who should deliver spiritual care; second, lack of confidence and competence in delivering spiritual care in palliative settings and third, difficulty identifying specific spiritual needs. National Institute of Clinical Excellence (NICE) guidance on spirituality is clear that spiritual care is the responsibility of all health professionals, although some patients may have specialised needs. Increased education to enhance spiritual care delivery is called for in healthcare training. The NICE guidelines for supportive and palliative care incorporate Marie Curie’s competency levels for spiritual care. The competencies cover all healthcare professionals in contact with patients who have palliative care needs. There are four levels of expertise defined, and each associated with competencies for knowledge, skills and actions (see Box 1). Specialised groups such as the clergy are working at level 4, which includes the education and training of others in spiritual care. The Marie Curie competency levels were developed by the consensus because there have been few empirical works in the United Kingdom on who should deliver spiritual care and at what level within specialist palliative care settings. There is a need for practical interventions to emerge from described theories of spirituality, as some research relates to practical evidence-based training in spiritual care provision.

It may be that a critical step in developing spiritual interventions that both meet patient needs and are deliverable within palliative care is to involve patients in spiritual care education and training. Increasingly, there are policy drives for service users to be more involved in research and service development particularly when needs are difficult to define.

Research is needed to determine the best ways of identifying spiritual needs and providing support to patients in different settings and at different stages of disease. Smith and Gordon have highlighted the dangers of a...
culture of specialisation of spiritual care, which could lead to deskilling of multidisciplinary teams. The theory behind our study was that gaining the perspective of patients could be used to facilitate professional development. The key message of this study is to report hospice patients’ views on how hospice staff (in any role or capacity) should be trained to deliver good spiritual care. It has been previously established that patients agree with the principle of spiritual care being available to those who want it.

Methods

Methodological approach
This is a qualitative study of hospice patients using semi-structured in-depth interviews with an explicit focus on professional training for spiritual care delivery. A qualitative interview approach is an appropriate method to obtain patient perspectives. One-to-one interviews were chosen in recognition of this area often being viewed as belonging to the personal sphere.

Objectives
The objectives of this study are to understand hospice patient(s) perspectives on the challenges of meeting spiritual needs and to describe patient suggestions for the development of professional training to deliver spiritual care.

Setting
This study took place within a hospice in the north of England. The setting was chosen as it represents a key population targeted by guidelines and end of life policies for spiritual care. During the study period, there was one whole time equivalent chaplain post at the hospice (with two sequential incumbents during the data collection period). There were also several volunteers who worked with the chaplain. However, the hospice supports the view that spiritual care is the responsibility of all staff and it is included in the admission pro forma.

Participants
Patients were invited to participate if receiving inpatient, outpatient or day care at the hospice. Staff identified patients who met the inclusion criteria (physically able and willing to participate in an interview) and then selected them sequentially from these lists. Additionally, arbitrary samples of patients throughout the hospice were invited to consider participation. The information leaflet explicitly stated this study was about spirituality (not confined to religion) but avoided offering definitions of what this might include to avoid prejudicing patients’ personal views. Patients could opt into the study by responding and providing written consent. Exclusion criteria were a preference not to participate at any stage, being unable to provide informed consent or being physically unable to participate in an interview in any format. Patients were offered additional support if the interview raised concerns.

Data collection
Ethical approval was obtained. A topic guide (Box 2) was prepared for each interview, reflecting iterative changes from previous interviews. All interviews were conducted in private rooms. Interviews were semi-structured, allowing patient’s flexibility to determine content and direction. Interviews (30–105 min) were recorded and fully transcribed, supported by detailed field notes. Data were collected over 3 months in 2007 by one author (SY) who is a doctor training in palliative medicine. Three patients had communication difficulties necessitating the use of

Box 1 Overarching components of the Marie Curie model

1. Competency development according to depth of patient contact (see levels below)
2. Guide to achieving competency objectives
3. Suggested tools: training and education, case-based and personal development reviews and (self) assessment documents
4. Suggested items for competency portfolio
5. Examples of audit tools for organisations
6. Pilot study describes delivery of the model through seminar training sessions with positive outcomes and improvements

Level 1
All staff and volunteers who have casual contact with patients and their families

Level 2
Staff and volunteers whose duties require contact with patients and their families/carers

Level 3
Staff and volunteers who are members of the multidisciplinary team

Level 4
Staff or volunteers whose primary responsibility is for the spiritual and religious care of patients, visitors and staff

‘culture of specialisation of spiritual care’, which could lead to deskilling of multidisciplinary teams. The theory behind our study was that gaining the perspective of patients could be used to facilitate professional development. The key message of this study is to report hospice patients’ views on how hospice staff (in any role or capacity) should be trained to deliver good spiritual care. It has been previously established that patients agree with the principle of spiritual care being available to those who want it.
alternative materials in addition to audio recording interviews.

Data analysis
The transcribed interviews, with accompanying field notes, were entered into NVivo 7™ (QSR International, Doncaster, Victoria, Australia). Following familiarisation with initial data, a thematic coding scheme was developed and constantly amended until data saturation occurred. Text was read as a whole and reread code by code before developing themes. Similarities and differences across subgroups were looked for in the data.

Techniques to enhance rigour included independent analysis of data by CW and use of data extracts to support developing themes. Patients were given the opportunity to provide feedback on the emerging results. Ten patients returned comments, all of which supported the emerging analysis. Details of all patients’ characteristics are summarised in Table 1. This sample is consistent with the hospice population during the recruitment period and hospice demography within England.

Findings
This article focuses on suggestions generated for training to deliver spiritual care. Patients were clear that spiritual care should be integral to hospice services. Their definitions of spirituality focused around meaning and purpose in life, and answers to questions regarding spiritual care were often referenced to feelings:

I think it would be good if you could always get to talk to someone when you are feeling really down or not well… even if they only talk to you to put your mind at rest (I2 discussing how spiritual care should be available)

Patients thought it is better to have opportunities to refuse care than not to be offered it. Training suggestions emerging from the analysis divide into four interrelated themes of knowledge, attitudes, skills and actions.

Knowledge about barriers and facilitators of spiritual care
Patients described barriers to spiritual care delivery relating to reluctance to engage in ‘spiritual talk’ and the need for it to be provided outside explicit religious roles:

spirituality in general I think people don’t readily talk about it, I think it is something they wonder about it, private but…that they don’t easily voice, maybe because…it is quite an emotional subject (I18)

…I just don’t believe that someone who is actually trying to offer a spiritual comfort to dying patients should be clergy, they can be – but I don’t think it is necessary for them to be at that level (I15)
There was an expectation that any healthcare professionals could deal with initial care to meet spiritual needs alongside a recognition that those with more experience or training were needed to support both their colleagues and patients. A general knowledge of differing world views was desirable amongst professionals, but these patients were looking for professionals with whom they could personally identify and ‘open up to’ rather than ‘expertise’.

**Attitudes towards spiritual care**

Patients were clear that attitudes were the most important area for training. They felt able to establish who was willing to identify with them without falseness and who took an interest in them as a person:

…I think you can have someone who is caring and good at their job and you can have people who are good at their job but not as caring

(I6)

Training was thought necessary to teach people to elicit, recognise and meet individual needs:

he [staff member] validated what I was thinking, he didn’t make any judgments...and at my pace we were allowed to explore that in a little bit more detail and I have a good enough relationship...to feel I could discuss it again with him

(I1)

No participant felt they would mind being asked questions about spirituality, and several thought it would be a positive step if done with a caring and professional attitude:

someone could chat with you and ask you those questions in an informal way to get the background really...I would want to know more about what they were searching for but I wouldn’t mind answering any questions like that

(I11)

Several patients expressed an interest in knowing what professionals thought about spiritual issues and described circumstances in which this was acceptable:

If I was sitting talking to a member of staff...then I wouldn’t mind in the slightest if they were giving their own opinions of things because we are not talking preaching... we are talking about something we are both interested in

(I14)

It seems from this data the ‘right’ attitude that patients are looking for is one of caring, interest in the individual, willingness for staff to share of themselves and engagement with the patient that is non-judgmental, on an equal basis and unhurried.

**Skills in meeting spiritual needs**

Patients wanted to share in care planning and delivery and thought that they should have control over the prioritisation of care issues, spiritual or otherwise:

everybody has different needs... recognising the core of that student’s needs which is a similar thing to being patient centred isn’t it...that is what I would be looking at

(I12, a teacher)

They valued professionals who were comfortable with uncertainty and who built relationships where concerns could be addressed sensitively:

I think that [staff developing skills via training] is very important...it’s a huge step. I guess it would be okay to turn around and say do you know I have often thought about that myself and I don’t have an answer, but if you talk to this member of staff she might be able to help you a little bit more than I

(I13)

Professionals should practice asking questions about spiritual care to find natural ways of engaging with patients:

what kind of training, well first of all a new patient comes in and you get to know the patient...First of all you would have to ask, you wouldn’t impose it on them...you would ask them first

(I20)

and show active listening and empathy:

all you can do is train somebody to recognise the individual, that they have needs whether they are nine or ninety they need to be listened to and they need to be valued

(I12)

It was seen as legitimate for professionals to facilitate conversations and to offer spiritual care in a way that implied no obligation but gave opportunity to patients who did not feel confident to raise the issue:

I think it’s attitude, and if they approach you rather than you approaching them, you can do if you want to but what I have noticed is they make sure that they
come round and speak to you individually...if you don’t want to that is fine as well

(I6)

The skills required to do this reflect those of communication in general – a respect for others and developing a way to interact sensitively with individual patients.38

Actions for assessment and practical delivery of spiritual care

Training programmes for spiritual care need to address the hurdle of moving from theory to practice. At the time of this study, there was no formal spiritual care training programme per se in the hospice, although this topic was included on the in-service training topic list. Participants did not specify who should deliver training beyond suggesting that more experienced professionals should mentor newer members of staff:

I suppose as a team everybody must meet together and talk about these issues

(I13)

Some suggested that ‘real’ patients could be used in training to provide feedback and that staff might draw on their previous interactions with patients to make suggestions or prompt thought around issues with current patients.

I also think in terms of training that it’s useful sometimes to have real patients and I think it is really important that people, staff are open and listening to criticism constructively

(I1)

In regard to sample questions (to initiate spiritual care discussions) that were shown to patients, they felt that three might be particularly useful:

• ‘What principles do you live by?’
• ‘Do you have a personal faith?’
• ‘Have you ever prayed about your situation?’

Surprisingly, these were not interpreted as being confined to ‘religious’ needs. Actions which patients felt would facilitate conversations are those used in communication skills training: considering atmosphere and environment, explaining motivation, asking questions naturally and giving permission to patients to share without risking judgement.38-40 Participants were also keen to learn from others’ experiences and felt these could be a source of ideas which they could evaluate the usefulness of for themselves.

Discussion

Individualised patient choice is current policy21,30 as is spiritual care regardless of diagnosis or prognosis. The patients in this study affirmed that meeting spiritual need was integral to palliative care, regardless of diagnosis and extent of hospice involvement. Spiritual need is also recognised but unmet in other healthcare settings.19 Evidence42 suggests recognition of professional uncertainty regarding spiritual care has not lead to changes in training. Current guidelines recommend using the Marie Curie model of reflective practice and competency frameworks to train healthcare professionals in spiritual care (Box 1).12,43 The uptake of this model is unknown, and training is not currently standardised.

This study provides patient validation to support increased use of the Marie Curie model and can contribute to training development by providing evidence of patient expectations, and it addresses identified difficulties in delivering optimal spiritual care. The patient perspective on uncertainty about who should deliver spiritual care is that it is a legitimate activity for all healthcare professionals.

Professionals working at higher levels of competency within the Marie Curie model should ‘act as a resource for knowledge, support, training and education for healthcare; interpersonal and communication skills; spiritual and religious care’.16 Some patients in this study suggested they would also be interested in participating in training professionals.

Questions of confidence and competence can be addressed by incorporation of this study’s findings into reflective experience-based training. The expectation that training should be given by those whose primary responsibility is for the spiritual care of patients, visitors and staff has been traditionally accepted in practice although there is a lack of evidence to support this. Questions remain about competencies and qualifications to deliver spiritual care training which are similar to the longstanding debate in spiritual care delivery.13 This later question has been partly set aside in practice by the requirement to follow the NICE guidance and work within the Marie Curie competencies. Marie Curie has piloted training models43 in 2004 and 2009 both of which were delivered by level 4 professional, in the latter case alongside a ‘practice educator’. The evaluation of these pilots shows a positive response to the training as a whole.

These patients felt that identifying specific spiritual needs could be facilitated simply by professionals raising the subject, asking questions as outlined above and engaging in individual discussions over time. Patients did not want spiritual assessment to be a ‘tick box’ exercise but flexible, allowing them to set the pace and agenda of conversations. This is a challenge to professionals, as the use...
of national assessment tools may only superficially meet what patients really expect. The importance placed on time and relationships provides patient perspectives on the value of ‘knowing the patient’, the ability to understand an individual and the ability to select appropriate interventions for them. A change in training that might facilitate this is involving volunteer patients to discuss and practise spiritual care assessment and delivery before developing skills as part of everyday practice. The patients in this study supported staff introducing questions about spiritual needs into conversation, which they could choose to answer or not. These results show that patients want to engage in two-way relationships and neither expect nor think it appropriate for healthcare professionals to consider themselves ‘expert’ before attempting spiritual care. Religion was considered independent of spiritual need; not only those without religious affiliation did express spiritual needs but also those with recognisable religious beliefs drew distinctions between ritual religious needs and spiritual needs. This has not been clearly documented before.

Training should include practice to develop coherent ways of explaining why questions are asked to avoid concerns about a hidden agenda. Professionals must be aware of boundaries they set between personal and professional roles and to consider whose benefit these are for and whether the boundaries are necessary. The findings of this data have been shared informally with professionals by delivering educational sessions based on questions recommended by patients to open conversations regarding spiritual care, identified barriers and facilitators and suggestions for professional development. The work has been well received with positive engagement and feedback.

**Strengths and weaknesses of this study**

This study sought user ideas to advance spiritual care training. As one researcher was based within the hospice, the data collection process was flexible, which contributed to uptake. A weakness of this study is that patients were from a limited demographic background. Although reflecting the hospice population from which recruitment occurred, this limits transferability of findings into different settings without further work.

**Conclusions**

Spiritual care is important to hospice patients. Healthcare professionals should be competent in spiritual care delivery via an individualised two-way process. Attitude and willingness to engage are more important than the ‘right words’. Training should incorporate the sharing of patient perspectives to support learning through experience and reflection. Consideration of ‘spiritual questions’ deemed useful by these patients, alongside their perspectives on professional boundaries and expertise, could improve professional engagement in spiritual care delivery. Delivery of training with formal evaluation is required to further assess the practical application of these recommendations to palliative care practice. This study has potential to inform the development of standards for organisational audit of spiritual care provision, but further research is required to address the question of who should be training the providers of spiritual care education and training themselves.

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