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ORIGINAL REPORT

Addressing Spirituality Within the Care of Patients at the End of Life: Perspectives of Patients With Advanced Cancer, Oncologists, and Oncology Nurses

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ABSTRACT

Purpose
Attention to patients' religious and spiritual needs is included in national guidelines for quality end-of-life care, but little data exist to guide spiritual care.

Patients and Methods
The Religion and Spirituality in Cancer Care Study is a multi-institution, quantitative-qualitative study of 75 patients with advanced cancer and 339 cancer physicians and nurses. Patients underwent semistructured interviews, and care providers completed a Web-based survey exploring their perspectives on the routine provision of spiritual care by physicians and nurses. Theme extraction was performed following triangulated procedures of interdisciplinary analysis. Multivariable ordinal logistic regression models assessed relationships between participants' characteristics and attitudes toward spiritual care.

Results
The majority of patients (77.9%), physicians (71.6%), and nurses (85.1%) believed that routine spiritual care would have a positive impact on patients. Only 25% of patients had previously received spiritual care. Among patients, prior spiritual care (adjusted odds ratio [AOR], 14.65; 95% CI, 1.51 to 142.23), increasing education (AOR, 1.26; 95% CI, 1.06 to 1.49), and religious coping (AOR, 4.79; 95% CI, 1.40 to 16.42) were associated with favorable perceptions of spiritual care. Physicians held more negative perceptions of spiritual care than patients ($P < .001$) and nurses ($P = .008$). Qualitative analysis identified benefits of spiritual care, including supporting patients' emotional well-being and strengthening patient-provider relationships. Objections to spiritual care frequently related to professional role conflicts. Participants described ideal spiritual care to be individualized, voluntary, inclusive of chaplains/clergy, and based on assessing and supporting patient spirituality.

Conclusion
Most patients with advanced cancer, oncologists, and oncology nurses value spiritual care. Themes described provide an empirical basis for engaging spiritual issues within clinical care.

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INTRODUCTION

Religion and spirituality (R/S) is central to how many patients cope with terminal illness and find hope at the end of life (EOL).[1-4] Research has shown that spirituality preserves patients' quality of life (QOL) despite severe physical symptoms,[2,5,6] supports prognostic acceptance,[7] and protects against hopelessness and despair near death.[8] Patients with advanced cancer experience a particularly high burden of spiritual needs,[1,9] which may threaten their QOL.[10]

Spiritual care (SC) recognizes the role of R/S in illness and supports spiritual needs.[11,12] Although chaplaincy is a cornerstone of SC, studies indicate that 41% to 94% of patients want their physician to be attentive to R/S,[13-15] particularly in the setting of terminal illness.[16-18] National palliative care guidelines[12,19] recommend multidisciplinary provision of SC, emphasizing the role of physicians and nurses in assessment. R/S has further relevance to medical providers because of its importance to patients' EOL medical decisions.[16,20-22] Finally, spiritual support from medical providers is associated with improved QOL,[2] satisfaction with medical care,[23-25] and lower rates of aggressive EOL care.[26] Despite these potential benefits and national guidelines,[12,19] engagement of patient spirituality remains controversial[27,28] and occurs rarely.[2,23]

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A barrier to SC is the paucity of data to guide its provision and inform clinician education.[29] It is unclear what forms of spiritual engagement are acceptable or supportive to patients, and it is also unclear how clinicians can best support R/S within their professional boundaries. Although SC is most relevant to patients at EOL,[17,18,30] most research has studied non–terminally ill populations.[13,14,16-18,31] Existing research is further limited by over-reliance on quantitative methodology, which is inadequate for generating a nuanced understanding of this topic.

The Religion and Spirituality in Cancer Care (RSCC) Study is a multi-institution, cross-sectional study of patients with advanced cancer, oncology physicians, and nurses that examines perceptions of SC and uses mixed qualitative and quantitative methods.

PATIENTS AND METHODS

Study Sample

Enrollment ran between March 2006 and April 2008 for patients and October 2008 through January 2009 for practitioners. Patient eligibility criteria included diagnosis of an advanced incurable cancer, active receipt of palliative radiation therapy, age 21 years or older, and adequate stamina to undergo a 45-minute interview. Patients were excluded if they did not speak English or Spanish or if they met criteria for delirium or dementia by neurocognitive examination.[32] Oncology physicians and nurses were eligible if they cared for patients with incurable cancer.

Study Protocol

Patients and practitioners were recruited from Beth Israel Deaconess Medical Center, Boston University Medical Center, Brigham and Women's Hospital, and Dana-Farber Cancer Institute, all in Boston, MA. All attending radiation oncologists at participating institutions allowed patient recruitment from their clinic schedule. Radiation oncologists' schedules were sequentially selected for patient recruitment; all eligible patients scheduled within a 1-week period were approached for study participation.

Oncology physicians and nurses were identified from medical, surgical, and radiation oncology departmental Web sites and e-mail databases. Each participating site's institutional review board approved the study protocol. All patients provided written informed consent. The institutional review board–approved "implied informed consent" for practitioners was based on elements of informed consent within the survey. Patients underwent a 45-minute semi-structured interview led by a trained research team member. Practitioners were contacted via e-mail and asked to complete a 15-minute Web-based survey. Of 103 patients approached, 75 (response rate, 73%) participated. Five patients were too ill to complete the interview and two omitted the main question analyzed here, yielding 68 (90.7%) of 75 patients. Of 537 physicians and nurses contacted, 339 responded (response rate, 63%; 59% among physicians; 72% among nurses). Eight practitioners indicated that they did not provide care to patients with incurable cancer, and 13 did not finish the questionnaire, yielding 318 (93.8%) of 339 respondents (204 physicians; 114 nurses).

Study Measures

Demographic and clinical variables. Age, sex, race/ethnicity, income, and education were reported by the patient. Cancer diagnosis and Karnofsky performance status were obtained from physician assessment. Survival from date of enrollment was obtained from the patients' medical records or the Social Security death index. Practitioners reported sex, age, race/ethnicity, field of oncology, and years of practice.

R/S variables. Patients and practitioners reported religious tradition and frequency of attendance at religious services. Two items from the Fetzer Multidimensional Measure of Religiousness/Spirituality for Use in Health Research[33] assessed participants' religiousness and spirituality. Pargament's Brief RCOPE (a 14-item measure of religious coping with major life stressors)[34] assessed patients' use of positive religious coping (eg, seeking spiritual support, religious forgiveness). Patients were asked if they had ever received SC from a cancer physician or nurse.

SC was defined within the survey as "care that supports a patient's spiritual health," followed by eight examples (eg, asking about a patient's religious/spiritual background). All participants were then asked, "What if cancer doctors and nurses regularly provided spiritual care? Assume the spiritual care is done in an appropriate, sensitive way . . . [example]. How positive or negative do you think this would be for cancer patients?" Responses ranged from 1 (very negative) to 7 (very positive) on a 7-point Likert scale. These eight spiritual care examples and the full survey question are included in the Data Supplement. In addition, patients and providers explained their response in open-ended fashion. Physicians and nurses provided written explanation whereas patients' responses were recorded and transcribed verbatim.

Analytic Methods

Quantitative analyses. Differences between patients', nurses', and physicians' attitudes toward SC were analyzed by using the Kruskal-Wallis nonparametric test and Wilcoxon rank sum tests for pairwise comparisons with Bonferroni corrections. Fisher's exact test compared attitudes between patients who had versus those who had not previously received SC. The dependent variable was trichotomized (negative, neutral to slightly positive, and moderately to very positive) because of small numbers within individual response categories. Multivariable ordinal logistic regression models using backward selection analyzed relationships between participants' characteristics and attitudes toward SC (the dependent variable). Covariates considered in patient models included sex, race, education, marital status, income, religious tradition, religious service attendance, spirituality (moderately or very spiritual *v* slightly or not at all spiritual), religious coping (median split), and patients' prior receipt of spiritual care (yes or no). Covariates tested in physician and nurse models included sex, age, race, religious tradition, religious service attendance, and spirituality. Religiousness was omitted because of colinearity with spirituality. Statistical analyses were performed with SAS version 9.1 (SAS Institute, Cary, NC). *P* values were two-sided and were considered significant at less than .05.

Qualitative analysis. The protocol followed rigorous qualitative methodology—triangulated analysis, employment of multidisciplinary perspectives, and reflexive narratives—to maximize the transferability of interview data. Transcriptions were independently coded by A.C.P. and J.D. and were compiled into two preliminary coding schemes. Following principles of grounded theory, a final set of themes and subthemes emerged through an iterative process with input from A.C.P., J.D., M.T.B., and T.A.B. Transcripts were then independently recoded by S.A. and M.V.W. The inter-rater reliability score was high ($\kappa = 0.9$). Frequency of themes endorsed by patients, physicians, and nurses were compared by using χ^2 or Fisher's exact test.

RESULTS

Quantitative Assessment of Spiritual Care Perceptions

Sample characteristics are listed in Table 1. The majority of patients (53 of 68; 77.9%), physicians (146 of 204; 71.6%), and nurses (97 of 114; 85.1%) reported that regular provision of SC by physicians or nurses would be at least slightly positive for patients (Fig 1). Physicians' perceptions were significantly more negative than those of patients ($P = .008$) and nurses ($P < .001$). A notable proportion of patients (12 of 68; 17.6%), physicians (32 of 204; 15.7%), and nurses (eight of 114; 7%) thought that routine SC would have a negative impact on patients.

Previous receipt of SC was significantly associated with a favorable perception of routine SC ($P = .012$; Table 2). In multivariable patient models, increasing education (adjusted odds ratio [AOR], 1.26; 95% CI, 1.06 to 1.49; $P = .009$), religious coping (AOR, 4.79;

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Table 1. Characteristics of Patients With Cancer, Oncology Physicians, and Oncology Nurses

Characteristic	Patients (n = 68)				Physicians (n = 204)				Nurses (n = 114)				
	No.	%	Mean	SD	No.	%	Mean	SD	No.	%	Mean	SD	P^*
Female sex	32	47.1			86	42.0			112	98.2			< .001
Age, years			60.2	11.9			40.9	9.9			45.4	9.2	< .001
Race/ethnicity													
White	57	83.8			155	76.0			108	94.7			
Black	7	10.3			4	2.0			2	1.8			
Asian American, Indian, Pacific Islander	1	1.5			35	17.2			2	1.8			
Hispanic	1	1.5			3	1.5			1	0.9			
Other	2	2.9			0	0			0	0			< .001
Education			15.2	3.4			—				—		—
Religiousness													
Not at all religious	13	19.1			62	30.4			29	25.4			
Slightly religious	25	36.8			66	32.4			33	28.9			
Moderately religious	17	25.0			54	26.5			43	37.7			
Very religious	13	19.1			17	8.3			7	6.1			.02
Spirituality													
Not at all spiritual	5	7.4			30	14.7			6	5.3			
Slightly spiritual	14	20.6			57	27.9			18	15.8			
Moderately spiritual	24	35.3			75	36.8			58	50.9			
Very spiritual	25	36.8			37	18.1			30	26.3			< .001
Religious tradition													
Catholic	32	47.1			47	23.0			70	61.4			
Other Christian traditions	22	32.4			45	22.1			17	14.9			
Jewish	5	7.4			51	25.0			6	5.3			
Muslim	1	1.5			2	1.0			0	0			
Hindu	2	2.9			3	1.5			2	1.8			
Buddhist	0	0			11	5.4			0	0			
No religious tradition	2	2.9			22	10.8			6	5.3			
Other	4	5.8			18	8.8			11	9.6			< .001
Cancer diagnosis													
Lung	23	33.8			—				—				
Breast	10	14.7			—				—				
Colorectal	6	8.8			—				—				
Hematologic/lymphoma	11	16.2			—				—				
Prostate	5	7.4			—				—				
Melanoma	2	2.9			—				—				
Other	11	16.2			—				—				—
Clinical characteristics													
Karnofsky performance status			70	20.6			—				—		
Survival, days			175.5	311.2			—				—		
Field of oncology													
Medical	—				110	53.9			90	78.9			
Radiation	—				46	22.5			13	11.4			
Surgical	—				32	15.7			7	6.1			
Palliative care	—				16	7.8			4	3.5			< .001
Years in practice													
Resident or fellow	—				67	32.8			—				
1-5	—				35	17.2			24	21.1			
6-10	—				34	16.7			24	21.1			
11-15	—				23	11.3			14	12.3			
16-20	—				20	9.8			11	9.6			
21+	—				25	12.3			41	36.0			—

NOTE. Because of missing data, percentages may not add up to 100.
Abbreviation: SD, standard deviation.
*χ^2 tests used for categorical variables and analysis of variance for continuous variables.

95% CI, 1.40 to 16.42; $P = .013$), and previous SC (AOR, 14.65; 95% CI, 1.51 to 142.23; $P = .021$) were significantly associated with positive perceptions of SC. Other patient characteristics were unrelated to perceptions of SC.

In multivariable physician models, younger age (AOR, 1.06; 95% CI, 1.03 to 1.09; $P < .001$) and spirituality (AOR, 5.39; 95% CI, 2.89 to 10.08; $P < .001$) were associated with positive perceptions of SC. No characteristics of nurses were

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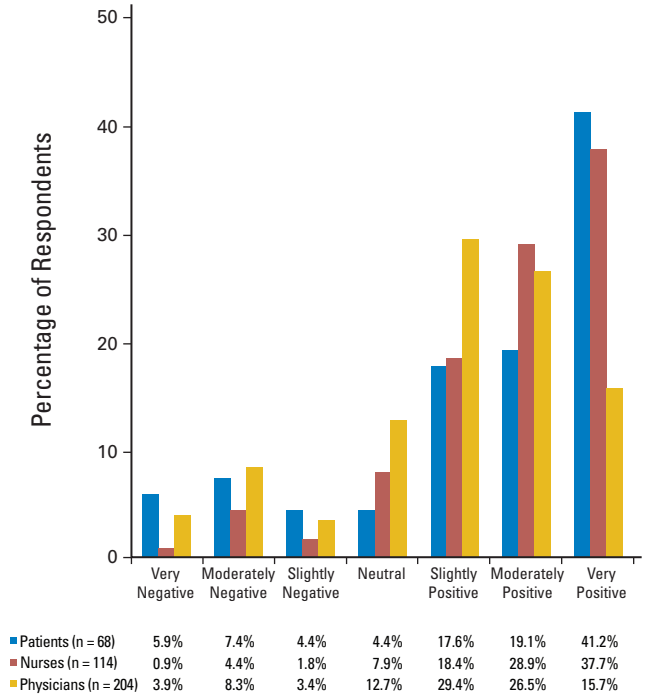

Fig 1. Attitudes toward spiritual care among patients with cancer, oncology physicians, and oncology nurses. Differences between patients,' nurses,' and physicians' responses were tested with a Kruskal-Wallis test, yielding $P < .001$. Pairwise comparisons between patient and physician and between physician and nurse were evaluated with Wilcoxon rank sum tests with Bonferroni corrections; $P = .008$ and $P < .001$, respectively.

significantly associated with perceptions of SC in univariate or multivariate analyses.

Qualitative Spiritual Care Themes

Three primary themes were identified within respondents' open-ended explanations of their perspectives toward SC (Table 3): (1) potential effects of SC on patients and/or the patient-provider relationship, (2) attitudes toward SC in the clinical care of patients with cancer, and (3) characteristics of appropriate SC delivery. Frequency of spiritual care themes and subthemes are reported in Table 4.

Within the effects of SC theme, participants most frequently noted its potential benefits (154 of 380) on patient well-being (55 of 380) and the patient-provider relationship (21 of 380). SC was proposed to benefit patient well-being through providing emotional, psychological, and spiritual support, with rare comments mentioning benefits to physical health. One patient commented, "I think it is an opportunity for the patient and the doctor to enhance their relationship with each other and with God. I think it would be a comforting experience. I think that it would be kind, and it might give the cancer patient more opportunities to receive something that the cancer has taken away. Because let's face it, cancer is about loss, so it [spiritual care] is a way of replenishing wealth." Possible negative effects of SC (43 of 380) included the potential to offend patients or to harm the patient-provider relationship. Many participants (116 of 380) noted that the effects of SC are not uniformly beneficial or harmful but are conditional on each patient and provider. One patient who rated routine SC as very positive warned, "If the person isn't spiritual . . . it could really make a conflict for them . . . I mean you can ask, and if they say no, then that's it. Drop it." A physician explained, "This may support some religious patients. In other cases, patients may be put off in that they would think their oncologist is turning to spiritual guidance as they do not have effective medical therapies."

Participants expressed both positive and critical attitudes regarding the role of SC in medical practice. Positive attitudes (85 of 380) included the belief that physicians and nurses should treat the whole person, that R/S is important to many patients, and that cancer evokes spiritual needs. One physician stated, "I think attention to meaning and spirituality is missing in many aspects of our culture and society. It is particularly important for those facing death or serious illness." Several participants framed their responses within a holistic philosophy of care. "It represents the holistic nature of nursing . . . [if a patient says]'I am an atheist, but my family was very religious,' this gives the nurse a great deal of useful information for individualized end-of-life care." A patient explained, "When talking about healing and taking care of patients, [physicians and nurses] have to think about the body, the mind, and spirituality. Think of the person as a whole."

Some respondents articulated critical attitudes toward SC (81 of 380). More than one quarter of physicians (54 of 202) suggested that SC was outside their professional role and training. "It's not really our role to provide this care. We're not trained in it and there are others available who would be better." Similarly, a patient stated, "I don't think most doctors have background or education in religion or spirituality. I don't think that's why patients seek them out . . . The time that doctors have with patients is very short, and there is a struggle to get enough time to even discuss medical issues in a way that is clear and helpful." Some of the other criticisms included that R/S is a private matter and the belief that spirituality and medical care should remain separate.

The third theme identified—appropriate delivery of SC—was defined as the necessary characteristics of SC. Many participants commented on the ideal content of SC (86 of 380), which included assessing patient R/S (45 of 380), supporting patients' spiritual beliefs and needs (33 of 380), and avoiding proselytizing or spiritual counseling (16 of 380). One patient reflected on the benefits of spiritual assessment, "I think that doctors . . . would encourage patients to express their spiritual problems and especially the fear of death and the other side, and patients wouldn't feel so afraid, and that stuff would not be untouched." A physician commented "I think it is fine to ask a patient about their religious/spiritual background . . . but spiritual guidance should be directed by a chaplain." Other characteristics of appropriately delivered SC included involving chaplains/clergy (46 of 380),

Table 2. Patients' Rating of Routine Spiritual Care According to Receipt of Previous Spiritual Care From an Oncology Physician or Oncology Nurse

	Receipt of Spiritual Care Before Survey*			
	No (n = 48)		Yes (n = 16)	
Spiritual Care Rating	No.	%	No.	%
Negative	11	22.9	0	0
Neutral to slightly positive	12	25	1	6.2
Moderately or very positive	25	52	15	93.8

*Fisher's exact test ($P = .012$).

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Table 3. Main Spiritual Care Themes with Representative Quotations

Spiritual Care Theme	Representative Quotation
Effects on patients	
Positive effects	Patient— It would help lift him [the patient] up, give him joy, a sense of meaning, and realize they are not alone, and you're never alone but God is there with you and you are not by yourself.
	Patient—Because ultimately you probably will die from the diagnosis that you have gotten, so that if you are religious or spiritual it would be very helpful. You can feel better, even if it is just psychologically better, and not physically. Because sometimes they cannot do anything for you physically and it is what it is. But spiritually and mentally they can.
	Patient—It shows that they care about you as an individual; it is important that the doctor knows you, that you are spiritual and religious.
Negative effects	Physician—It takes away from the ability to deliver impartial medical care and asks of the doctor to practice in a realm she is not trained in.
Conditional effects	Physician—It would be highly dependent on the comfort level and style of the cancer doctor in the spiritual/religious area. If they were not comfortable, the experience for the patient could be quite negative. On the other hand, if comfortable, could be quite positive for the right patients.
Attitudes toward spiritual care	
Positive attitudes	Patient—When you are diagnosed with cancer you obviously face a life-threatening circumstance and you become acutely aware of your spiritual nature.
	Physician—Spiritual care is integral to good patient-centered care.
	Nurse—Nursing [utilizes] a holistic framework. I think the best nursing care includes spirituality.
Negative attitudes	Patient—I do not think it belongs in the medical relationship between the cancer patient and his doctors; the object of the exercise is to cure people not to get into religion and what you believe in.
	Physician—As a medical oncologist I am not trained to assess a person's faith or provide spiritual care. There is not enough time in provider visits to do this.
	Nurse—I believe spiritual care should be separate from physical care, more appropriate for the nurse to provide a chaplain.
Delivery of spiritual care	
Individualized to patient	Nurse—I feel individual assessment of what is supportive in each patient is key. Religious and spiritual are very different.
Voluntary for patient and provider	Patient—First of all, if the cancer patient is not religious and doesn't want to hear from the doctor about religion, then they should drop it. If the patient, and the doctor/nurse know that the patient is religious, and the doctor/nurse want to help them with that, then that is fine.
Include chaplains or clergy	Physician—I'm not sure that the physician is the best provider of spiritual care; I think that is better left to a chaplain or members of the patient's religious community.
Content of spiritual care	Physician—Once a diagnosis is made I ask, carefully where their strength and spiritual support comes from and encourage them to use it through the experience.
	Nurse—The nurse may be the only person who asks the patient about their spiritual beliefs and might open the door for conversation.

individualizing care to each patient (41 of 380), and ensuring that SC is voluntary for both patients and providers (36 of 380).

Examination of theme frequencies revealed notable differences between the perspectives of patients, physicians, and nurses (Table 4). Recognition of the positive effects of SC differed significantly among respondents ($P = .006$). For example, only 7% of physicians cited specific benefits of SC to patients' well-being compared with 30% of patients and 18% of nurses ($P < .001$). Patients, physicians, and nurses also expressed differing frequencies of positive attitudes ($P = .005$) and negative attitudes ($P = .018$) toward SC, with physicians being the most critical. The four most frequent subthemes cited by patients, physicians, and nurses also differed (Table 4), with physicians more often expressing reservations about their own involvement in SC and preferring to defer to chaplains/clergy.

DISCUSSION

This study provides an in-depth examination of the perspectives of patients with advanced cancer, oncologists, and oncology nurses regarding engagement of spirituality within the medical care of patients with advanced cancer. The majority of patients (77.9%), physicians (71.6%), and nurses (85.1%) believed that routine SC would at least slightly benefit patients. These attitudes compare somewhat favorably to those in other reports,[13,14,16,23,31] possibly because our survey question presupposed sensitive engagement of spiritual issues and pertained to EOL care—the setting in which patients consider spirituality most relevant.[16-18] Participants described SC as a source of emotional support, comfort, and a means to validate the spiritual dimensions of terminal illness. Despite these generally favorable perspectives, only 25% of patients had previously received SC. Some participants, especially physicians, expressed skepticism about the compatibility of medical and spiritual caregiving roles. Overall, our findings support attention to patients' spirituality within national guidelines for quality EOL care,[12,19] while highlighting some complexities inherent to addressing R/S within clinical care.

SC was proposed to benefit patients by supporting their spiritual and emotional needs. This is in keeping with prior research demonstrating the centrality of R/S to patients' ability to cope with[3,5,6] and accept terminal illness[7] and find meaning at the EOL.[4,8] R/S traditions offer teachings about hope, suffering, and life after death which can be profoundly relevant and comforting to patients with advanced illness.[4,15] Patients' previous receipt of SC was strongly associated with positive perceptions of routine SC. This association might reflect the propensity of religious/spiritual patients to have received SC; however, persistence of this association in multivariable models that include R/S

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Table 4. Frequencies of Qualitative Spiritual Care Themes Among Patients With Advanced Cancer, Oncology Physicians, and Oncology Nurses

Spiritual Care Theme	Patients (n = 66) No.	Patients (n = 66) %	Physicians (n = 202) No.	Physicians (n = 202) %	Nurses (n = 112) No.	Nurses (n = 112) %	P*
Effects on patients							
Positive effects	37	56	69	34	48	43	.006
Patient well-being	20	30†	15	7	20	18‡	< .001
Patient-provider relationship	7	11	10	5	4	4	.013
Negative effects	8	12	23	11	12	11	.959
Patient offense	1	2	9	4	7	6	.369
Patient-provider relationship	1	2	7	3	4	4	.851
Conditional effects	23	35	60	30	33	29	.703
Conditional on patient	19	29‡	46	23†	27	24†	.612
Conditional on spiritual care delivery	7	11	15	7	8	7	.665
Predisposing attitudes							
Positive attitudes	16	24	33	16	36	32	.005
Holistic care	7	11	8	4	12	11	.040
Religion/spirituality is important to many patients	5	8	7	3	8	7	.203
Cancer evokes spiritual needs	10	15	9	4	7	6	.011
Negative attitudes	16	24	72	36	24	21	.018
Professional role	10	15§	54	27¶	15	13	.009
Religion/spirituality is a private matter	3	5	2	1	2	2	.148
Religion/spirituality and medicine should be separate	2	3	6	3	4	4	.924
Delivery of spiritual care							
Individualized to each patient	11	17	14	7	16	14§	.031
Voluntary for patient and provider	9	14	14	7	13	12	.074
Include chaplains or clergy	6	9	30	15§	10	9	.217
Content of spiritual care	21	32¶	36	18‡	29	26†	.038
Religion/spirituality assessment	11	17	23	11	19	17	.307
Support patient's religion/spirituality	6	9	19	9	17	15	.252
No proselytizing or spiritual counsel	6	9	7	3	5	4	.194
Prayer	2	3	3	1	2	2	.685

*P value obtained from χ^2 test or fisher's exact test.
†Most frequently endorsed subtheme.
‡Second most frequently endorsed subtheme.
§Third most frequently endorsed subtheme.
¶Fourth most frequently endorsed subtheme.

characteristics suggests an effect of prior SC beyond confounders. Other studies confirm that SC is associated with patients' satisfaction with care[23-25] and improved QOL.[2,26] Consistent with one study from the family practice literature,[18] SC was also described to potentially strengthen patient-provider relationships by demonstrating personal care beyond professional obligation and enhancing providers' understanding of their patients.

An important minority of participants thought SC would be harmful. These viewpoints were often supported by categorical objections based on the privacy of R/S or a belief that spirituality and medicine are completely immiscible. Such objections should always be respected, and patients should retain control over the content and extent of R/S conversations with their providers. Less fundamental reservations about SC were much more common, including consideration for nonreligious patients, concerns about adequate clinician training and discordance of patient/provider beliefs, and recognition that complex spiritual matters are beyond most medical providers' expertise and scope of practice. Appreciation of these challenges was frequent, even among participants who rated routine SC favorably. When interpreted in context, these criticisms seldom reflected disapproval of SC but demonstrated a balanced understanding of its potential benefits, risks, and limitations. Furthermore, 30% of participants emphasized the theme of conditionality: SC was not viewed as uniformly helpful or harmful; rather, its effects were felt to be dependent on each patient, provider, and situation. In summary, although most patients and providers value SC, they also recognize the challenges and limitations of attending to patient spirituality within EOL care.

Although this specific analysis was not designed to comprehensively evaluate SC content, many participants offered their perspectives on this subject. Assessing and supporting patient R/S was described most commonly, with infrequent reference to prayer[35] or other particularly religious forms of care. These findings are consistent with an exploratory study from Daaleman et al[36] and affirm the emphasis of spiritual assessment within existing guidelines.[12,19] A spiritual history can be obtained within a few minutes,[37] and may uncover important issues that would benefit from chaplaincy involvement. Moreover, spiritual assessment fosters an environment open to sharing the existential, spiritual, and religious dimensions of illness.[9] Our data further suggest that SC should be individualized to each patient and include clergy/chaplains. SC should be entirely voluntary and not supersede good medical care, nor should clinicians proselytize. These cautionary points are self-evident and consistent with national guidelines.[12] In synthesis, participants largely described a model of SC founded within patient-provider relationships open to sharing and supporting the spiritual dimensions of terminal illness in a patient-centered manner.

Strengths of this study include use of quantitative and qualitative methodology, which are both necessary to provide a nuanced understanding of SC. In addition, this study enrolled the population shown to most want SC—those with terminal illness.[16,17] Limitations include recruitment from a single geographic region and limited ethnic diversity of patients. Given the relatively low religiousness/spirituality within the Northeast, national attitudes may be more favorable. Because qualitative research is limited by what participants spontaneously share, themes are likely underestimated, and therefore theme frequencies and differences identified between patients and providers should be considered hypothesis generating.

In summary, most patients with advanced cancer, oncologists, and oncology nurses believe routine SC would benefit patients. Our data suggest that SC, when offered appropriately and sensitively, could significantly enrich patients' emotional well-being and patient-provider relationships. Although physicians were particularly attuned to tensions between SC and professionalism, the patient-centered and circumscribed vision of SC described here seems at minimal odds with clinical responsibilities. Considering the infrequency of SC reported here and elsewhere,[2,16,23] physicians and nurses might be neglecting an important opportunity to improve the care of patients with advanced cancer.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

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