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Spiritual care: implications for nurses' professional responsibility

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Spiritual care: implications for nurses' professional responsibility

Aim. This paper aimed to gain insight into the spiritual aspects of nursing care within the context of health care in the Netherlands and to provide recommendations for the development of care in this area and the promotion of the professional expertise of nurses.

Background. International nursing literature suggests that caregivers are expected to pay attention to spiritual aspects of patient care. In Dutch nursing literature, the spiritual dimension is increasingly becoming a focus of attention. Despite this, there is a lack of empirical data from professional practice in the Netherlands.

Method. Data were collected by means of focus group interviews. The sample was made up of the specialist fields of cardiology, oncology and neurology and divided into groups of patients, nurses and hospital chaplains. The interviews took place between May and December 2004. Data were qualitatively analysed using the computer programme Kwalitan.

Results. Different spiritual themes emerged from the interviews. There were different expectations of the nurse's role with regard to spiritual aspects. The main themes derived from this research can be recognized as aspects of nursing competencies that are reported in the literature. However, the attention to spiritual aspects in the nursing process is not clear cut. It seems to be highly dependent on personal expression and personal commitment.

Conclusions. The study raises questions about the nurse's professional role in spiritual care. The study shows that different factors (personal, cultural and educational) play a role in the fact that spiritual care is not structurally embedded in nursing care. Further research on the impact of that variable is recommended.

Relevance to clinical practice. Nursing care implies care for the spiritual needs of patients. To provide this care, nurses need to be knowledgeable regarding the content of spiritual care and the personal, professional, cultural and political factors

influencing it. They also need to be able to participate in policy and decision-making discussions of spiritual care in clinical nursing practice.

Key words: focus groups, nurses, nursing, professional, responsibility, spiritual care

Introduction

The role of spirituality in health and health care is recognized by health professionals (Koenig 2002). The claim that nurses should take account of aspects of spirituality derives from an holistic perspective on human functioning and in nursing (O'Brien 1998, McSherry 2000). Narayanasamy (2000) takes an ideal view of health care with spirituality forming part of an holistic perspective. By this he means that a human being consists of body, mind and spirit and that these dimensions are interconnected and interdependent. Spirituality, therefore, is an integral part of the nursing domain. There is an increasing research base for spiritual care (O'Brien 1998, McSherry 2000, Narayanasamy 2000, Taylor 2002). On the contrary, nursing is becoming an increasingly important source of insight into the relationship between aspects of spirituality, health and health care. However, certain aspects of the topic are contested, such as the conceptualization of spirituality and the nurses' role in providing spiritual care. McSherry *et al.* (2004) emphasize the different conceptualizations of spirituality in the nursing literature. They conclude that the goal of achieving a universally accepted definition of spirituality would seem to be impossible. They argue that a person's view of the concept depends on his or her view and interpretation of the world. These authors present a classification of the different meanings of the concept of spirituality, on a continuum ranging from a strictly religious meaning at one end to a strictly humanistic, existential meaning at the other. This multidimensional approach is not only a result of philosophical analysis, but can also be concluded from empirical evidence (Flannelly *et al.* 2002, Johnston Taylor 2005). Flannelly *et al.* (2002) implicitly emphasize the multidimensional approach of spirituality by holding that a strictly religious interpretation of spirituality is problematic for an adequate assessment of the spiritual needs of, particularly, non-religious patients. van Leeuwen & Cusveller (2004) accept the multidimensionality of spirituality by choosing what they have termed a functional approach to spirituality (Fitchett 1993). They describe spirituality as the religious and existential mode of human functioning, including experiences and the questioning of meaning and purpose (Jochemsen *et al.* 2002). This definition reflects the view that human beings express their common function of spirituality in

different forms and content. This functional definition is used in the study that is reported in this paper.

Reviews show that there has been research into aspects of spiritual care in various settings. On the basis of a review of nursing journals for gerontology, Weaver *et al.* (2001) found that religion and spirituality are of great importance for older patients in clinical situations. Spirituality, they suggest, plays a vital role in the lives of older people who are suffering from illness. They also found that nurses are strongly confronted with their own spirituality when delivering spiritual care to patients, which means that providing spiritual care for the patient, in fact, also affects the nurse. From a review of nursing journals for oncology, Flannelly *et al.* (2002) found that there are different expectations between nurses and hospital chaplains regarding the role of nurses in providing spiritual care. These differences mainly focus on when a nurse should refer the patient to the hospital chaplain. The issue in question is whether nurses can handle certain aspects of spirituality by themselves and, consequently, when referral is needed. Narayanasamy (2001) emphasized that there is confusion about the role of nurses in relation to spiritual care and they identified different perspectives from which nurses approach spiritual care (personal, procedural, cultural and evangelical). This study shows the different dimensions of spiritual care.

van Leeuwen & Cusveller (2004) described three domains of nursing competencies for spiritual care on the basis of a literature survey. These domains are self-awareness and communication, spiritual dimensions in the nursing process and quality assurance and expertise development on spiritual care. They suggest that, despite the descriptions of these competencies, there is still confusion with regard to distinctions between the professional responsibility of nurses and that of other healthcare professionals.

In summary, nursing literature shows that spirituality and spiritual care are part of the nursing domain, but that there are still questions to be answered about the content and borders of spiritual care in nursing. Little empirical data are available from Dutch health care about this aspect of nursing. More research was needed to explore spiritual care and to contribute to the discussion on this aspect of nursing care. On the basis of these considerations a qualitative focus group study was performed within the context of clinical somatic health care in the Netherlands in May–December 2004.

The study

Aim

The aim of the study was to answer the question in what way do nurses pay attention to aspects of spirituality of patients within the context of Dutch clinical somatic health care and what can be inferred from this empirical data with respect to the professional role of the nurse in spiritual care. The purpose of this study was to contribute to the debate on the nurse's role in spiritual care on the basis of that empirical evidence.

Methodology

Data were collected by means of focus groups in the form of group interviews. The focus group method is a form of qualitative research that uses accepted systematic procedures for data collection, data handling and data analysis. In the case of this study, the method allowed the researchers to obtain in-depth perceptions of people in a complex topic like spiritual care (Krueger & Casey 2000). In particular, the group-dynamic effect allows participants to recognize each other's experiences in relation to spiritual aspects, as well as pointing out similarities and differences and encouraging them to consider or reconsider their own experiences and views. The group size created a confidential atmosphere, which allowed an in-depth study. The role of the discussion leader was of vital importance in ensuring that all participants could have their say during the discussions. In reality, some participants are more dominant than others, which can hinder the collection of data, in turn affecting the reliability and validity of the research. Trial interviews and the debriefings following the interviews proved to be vitally important.

Sample

In this study a convenience sample, formed using a 'double layer design' (Krueger & Casey 2000) was used, consisting of the specialist fields of cardiology, oncology and neurology, which were further divided into groups of patients, nurses and hospital chaplains. The following criteria were used for the sample:

- Nurses: qualified for a minimum of four years and working at least 50% of a full-time position.
- Patients: recent hospital experience (admitted within the past two years).
- Hospital chaplains: at least five years of professional experience.

Table 1 Focus group participants

Group	No. of groups	<i>n</i>	Characteristics
Patients	4	25	Male/female ratio 9/16 Average age 58 (range: 44–82) Average hospitalization 4.4 weeks (range: 1–30)
Nurses	6	30	Male/female ratio 2/28 Average age 39 (range: 28–54) Average work experience 10 years since obtaining a degree
Hospital chaplains	3	12	Male/female ratio 9/3 Average age 50 (range 33–58) Average of 12 years' professional experience

The specialities were selected based on a literature search (van Leeuwen *et al.* 2004), with a further distinction made between acute and chronic ailments. Table 1 contains the main parameters of the focus groups. The starting point was to form groups of 5–6 participants to guarantee sufficient opportunity for in-depth interviews. This was accomplished. Drop-out among participants is a problem when using focus groups, therefore eight participants were approached for each group. There were drop-outs in several groups as the result of illness, transportation problems and personal reasons. The participants participated voluntarily and were recruited through different means (patient contact groups, hospitals and professional organizations). Geographical spread was taken into account in this study and the ideological background of the participants was consistent with the Judeo-Christian and humanistic roots that characterize Dutch society. Ethical approval from an ethics committee was not necessary. There was no dependency of the participants and the research method was not burdensome or risky. Before the focus group members decided to participate they were given detailed information about the research and their role in it. They could withdraw at any time in the process.

Data collection

An interview schedule consisting of open questions was used for data collection. Each participant received information on the research in advance, including the following definition of spirituality: the existential or religious mode of human functioning, including experiences and questions of meaning and purpose (Jochemsen *et al.* 2002). This was performed to provide a spiritual frame of reference for the participants in the case they were not familiar with the word 'spirituality'. The interviews were recorded on minidisc and a written

report was made during each interview, setting out the main topics of the interview and salient non-verbal responses. Following each interview a debriefing was held by the interviewer and the research assistants.

Data analysis

The interviews were transcribed in full and this material was then qualitatively analysed per group and between the different groups using the computer program Kwalitan (Peters 2000). The reports from the debriefings were also included in the analysis. The analysis process consisted of the following steps:

- Segmentation and coding of transcripts.
- Describing substantial themes in a tree structure.
- Categorizing the themes and matching the characteristics of the fragments.

Validity and reliability

During the research, methodological measures were taken to ensure the reliability and validity of the research. These are recorded in Box 1.

Results

The following description of results will briefly address the themes that were derived from the interviews. These themes are illustrated with quotations from different participants of the interviews. Table 2 gives an overview of the themes that the analysis identified from interview texts. These are categorized into six nursing competencies for spiritual care (Leeuwen & Cusveller 2004). The table also provides more insight into the different dimensions of the themes, obtained as the result of the coding process.

Expectations of the role of nurses

Participants had different expectations concerning the role of nurses in spiritual care. Patients, in general, emphasize a need for the attention and presence of nurses and want nurses to display good professional skills, by which they mean physical care. In general, nurses wondered what their own responsibility was in this area. Hospital chaplains had opinions varying from being able to identify problems and making referrals to having reflective contact with patients:

Patient: Can you expect a nurse to be an all-rounder? Should he/she be an expert in psychology and religion as well as health care in order to have a conversation with you on these subjects?

Box 1 Reliability and validity measures applied in the focus group research (Lincoln & Guba 1985, Maso & Smaling 1998, Polit & Hungler 1999, Krueger & Casey 2000)

Making use of the definition/description of the term 'spirituality' and working with a topic list. Testing topic list in a trial interview
Trial interviews were held in order to develop the roles of interviewer and assistants
Keeping the roles of reporter/observer and the interviewer separate during interview
Debriefing by research group after each interview to discuss the initial impressions
Keeping a reflexive journal with methodological and theoretical notes on findings/thoughts connected with the research
Frequent meetings and discussions in the research group concerning the processing of interviews and analyzing the data
Peer debriefing: assessment of all steps in the research by a professional in the field of research and spirituality
Person triangulation: patients, nurses and hospital chaplains
Recording the interviews on audio and video tape, from which written transcripts were made in full and which were used for the analyses
Use of the computer program Kwalitan (Peters 2000) to process and analyse the research data
A written research report including all steps in the research
Verifiability of the research through systematic recording of all documents and reports
'Thick description': phenomena are described and explained in the research report, and illustrated by means of typical excerpts from interviews from the interviews

Nurse: I find it difficult to say whether it is part of my professional duty, or whether it is something personal.

Hospital chaplain: It is wonderful when nurses discuss questions about life with a patient, but it's just a lucky coincidence. I believe I don't expect it in general from nurses. Nurses mustn't think that they can solve everything, because they can't.

Nurses' own spirituality

Participants indicated that, in the case of spiritual care, it is important for nurses to show who they are and that they respond on a personal level. Patients wondered if they could expect the same from all nurses. Some nurses related that they had been spiritually moved by patients. For instance, when a patient is suffering or displays spiritual courage. Nurses appeared to be influenced by their upbringing, their personal history and experiences, which causes them to pay attention to spiritual aspects. Personal spiritual experiences of nurses also played an important role and these are not necessarily restricted to certain age groups. Patients noticed that older nurses pay more attention to spiritual aspects.

Table 2 Aspects of spiritual care in nursing

Nursing competencies for spiritual care (van Leeuwen & Cusveller 2004)	Themes derived from interviews	Dimensions
Handling one's own values and convictions	The nurse's spirituality	Reaction as a person, influenced by professional practice, has an influence on professional practice, role of upbringing, life history, life experience and professional experience, age
	Attitude	Sensitive, human, warm, patient, caring, careful, well-informed, a calling, involved, listening, attention, recognition, respect, non-judgemental, showing of self, holistic view, honest, unintrusive, not interpretive, courage, authenticity, enjoying life, trust, giving, taking time, solution-oriented vs. reflective, age, life experience
	Personal emotions	Inner conflict, being personally moved, strength–helplessness, importance of expressing emotions
Communication with the patient	Relationship of trust	Connection necessary, limited by admission period, recurrence, presence
	Communication skills	Empathizing, confirming, encouraging, expressing/channelling emotions, listening, not focused on solutions, taking time, right moment, non-verbal, challenging, breaking bad news
	Talking about spirituality	Circumstances: evening/night, same faith, spontaneous, needs time, familiar with spiritual/religious language, often coincidental, not structural
Establishing the need for care	Communication problems	Content: attention, illness process, future, getting things organized, telling of story (including past), death, last wishes, saying good-bye, family situation, helping get through difficult moments, preparing for major treatment, conversation with family/partner
	Anamnesis	Avoiding (aphasia, foreign language), generation gap, not enough time, misunderstandings/misassociations about spiritual issues, privacy (sharing room)
	Identifying spiritual needs	Time (can be too early), subject taboo, wrong associations by patient, defensive reactions
Care attuned to patient/disciplines	Planning/nursing plan/reporting	Anamnesis questions: some are asked, some not, which faith, need for pastor, church, meditation centre, religious experience, life style, wishes, values/convictions (Gordon), how were previous situations handled (coping), important periods in life
	Organization of care	Identifying: watching for emotions, ambiguous reasons; strange behaviour, if the nurse is personally moved
	Disciplines	Often not structural, depends on person, integrated as psychosocial functioning (coping), standard nursing plan 'ideological need'
Implementing and evaluating health care	Interventions	Little continuity experienced, depending on people, system of prime responsibility: nurse positive, spiritual advisor, discussion with team supervisor, volunteers/hostesses play a role
		Physician: questions surrounding resuscitation, quality of life, nurses standing up for patients
		Spiritual advisor: need/no need, preference for own pastor, relating to surgery and/or treatment
	Multidisciplinary meetings	Referral by nurse: at patient's request, own initiative, patient with strong beliefs, death situations, longing for old religious values, life questions, after breaking bad news, if nurse has no time, life full of struggles, indefinable questions, face-to-face conversation, comfort
		Social work: advice on finding purpose, referral by nurse
		Initiative often from spiritual advisor, raising awareness, input nursing depends on person, often a lack of time
	Interventions	Depends on person, attention during basic care, warmth, presence, physical contact, comfort, encouragement, conversation, care and attention to family, praying with patient (controversial/referral), terminal care, using tools for coping (looking at pictures, list of questions), setting priorities when it really matters

Table 2 (Continued)

Nursing competencies for spiritual care (van Leeuwen & Cusveller 2004)	Themes derived from interviews	Dimensions
	Evaluation Time	Especially after a difficult conversation, often stays between nurse and patient Patient realizes that nurse is busy, nurses feel they lack time, no time means not wanting to make time: referral to spiritual advisor
	Nursing team	Planned and spontaneous meetings, sharing, venting emotions and experiences, reflection, acceptability of treatment, quality of life, not able to figure things out by yourself, inner conflict, suffering, illness perception of patient and/or partner, creates a bond, support, understanding, trust, able to cope with work, cannot be discussed with all colleagues
	Cultural aspects	Positive ward culture: close team, outgoing culture, good information and guidelines, clear vision of care, daily personal attention, positive attitude of supervisor, good atmosphere Negative factors of hospital culture: dominance of medical-technical aspects, tension between cure and care, evidence-based work, commercialization
	Education Need to improve professional expertise	None during basic programme, but basic skills sufficiently trained, present in specialist programmes (oncology), practice learning is important Conversation techniques, developing sensitivity to the topic, becoming aware of one's own sense of purpose, experience important too, knowledge of religious/spiritual movements, language, traditions, sense of purpose at work

Nurse: My brother was killed in an accident when he was 20 years old. My father did not take it well and the worst possible thing happened: my brother was never mentioned again. My mother is 86 now and has lost another son. When we talk about it, which I do more often now, the pain is so sharp that she can burst out crying every time. This is how I came up with the idea of asking a patient 'how do you talk about it with your family?

Nurses indicated that, as they grew older and gained more personal and professional experience, they noticed and paid more attention to spirituality. Whether or not a nurse is religious also seems to have an effect. Patients noted differences between nurses who are religious or not. There was a certain recognition when they interacted, and some patients indicated that they had a better connection. Several patients stated that it must be the patient who initiates this type of contact. It was perceived in a negative way if a nurse imposed his/her faith too much. All participants were convinced that the relationship between patients and nurses must be based on trust. Hospital chaplains were under the impression that religious nurses were more likely to refer patients to them.

Attitude of the nurse

All participants pointed out which characteristics should be part of a nurse's basic attitude with regard to spiritual care.

Patients used words such as 'sensitive', 'human', 'warm', 'patient', 'caring', 'careful', 'well-informed' and 'involved' to describe this attitude. Some referred to it as a 'calling'. Nurses emphasized qualities such as showing respect and not judging people who have different religious views. Hospital chaplains believe that nurses are naturally inclined to find solutions. This is in contrast to the 'spiritual attitude', which requires more reflective qualities.

Hospital chaplain: Nurses must have a more reflective attitude, paying attention to the helplessness, sorrow and disappointment of the patient. These things can be communicated and shared while the patient is being washed or cared for. Nurses focus strongly on finding solutions: 'we have a problem and we will solve it'. There is much to be gained from listening to what is truly important to the patient.

Nurses' emotions

It seems that aspects of spirituality are also connected to certain emotions displayed by nurses. This became especially apparent during the interviews when situations of inner conflict were mentioned (how can this dying patient speak so positively about God?), being personally moved by a patient (confrontation with suffering) and feeling powerless (feeling that nothing can be done for the patient, or not being able to reach the patient).

Nurse: What I always find challenging is a patient who has a different view on life than I do. I try to accept people for who they are and respect them, and I do this. The other side of it is that I am confronted with myself, because I have different ideas about life.

In many cases, the nurse will not discuss these aspects with the patient, but it does lead to personal reflection. Nurses also mentioned situations in which they could barely handle the emotional burden and were personally hurt. This gave rise to ambivalent thoughts because some nurses said that these emotions should be permitted, but wondered whether this is right.

Nurse–patient communication

A wide range of spiritual topics was discussed in conversations between nurses and patients. Factors that may enhance the communication about spiritual issues between patient and nurse could be derived from the interviews. In many cases, conversations occurred during the evening and night shifts, when there was more time. It also appeared that such conversations started spontaneously, without any kind of planning. Openness on the side of the patient, as well as the nurse, determined whether such a conversation occurred. Another factor seemed to be whether the nurse and patient shared the same ideology and were able to recognize each other's religious language.

Nurse: I talked to a young woman with cancer. She does not have long to live. She has a young child and she said: 'I work and I'm often tired'. I try to start a conversation with her; umm, what do you want in this life?, what do you find important right now? – your work, your child, or both?

According to patients, a generation gap between the patient and nurse can be an obstacle. Some said that they talked more about spirituality with older nurses. Specific communication problems may cause a nurse to avoid contact with the patient (such as aphasia with neurology patients and patients who speak a different language). The lack of privacy in a room is also considered a decisive factor.

Nurse: Privacy is sometimes a difficult thing for patients who share a room with others. Sometimes you can't talk with a patient, or because he or she feels uncomfortable. Or sometimes the patients appear to be at different stages of coping or they deal with things differently. It can be very challenging when someone is constantly dealing with death while someone else is not.

Assessment and nursing plan

Spiritual aspects play a role in various ways in the assessment process. In many situations, this was limited to one or two

questions, such as whether the patient belongs to a religious community or would like to see a pastor. In some situations nurses seemed to ask further questions, for example, about the patient's spiritual views or how the patient has handled previous situations. Sometimes the topic of spirituality was not mentioned at all.

Nurse: With patients who have acute heart problems I do not bring it up because they will immediately think they are dying, which is not good at all. If you bring it up, you should do so gently at a later stage of the process, but in the acute phase, I think it is inappropriate.

Some nurses indicated that the intake interview is not the right time. In their view, the basis of trust is not yet there, which could trigger a defensive reaction from the patient ('they'll send a minister and I don't want that'). Generally, we observed that, in practice, no attention is paid to spiritual aspects in the nursing plans. Some of the oncology nurses recorded it as a coping problem, rather than a spiritual problem.

Nursing interventions

Important interventions in the area of spiritual care that were mentioned include aspects relating to the nurses' attitude and to communication. The decision to intervene seemed highly dependent on the personal choice of the nurse and was often spontaneous. An exception to the rule appeared to be care during the dying phase, when care seemed to be more structural. In a limited number of situations, nurses sometimes prayed with a patient. Patients appreciated it in these situations because it was their wish. Occasionally, this raised questions within the team. A few nurses used tools to talk about spiritual aspects, such as pictures to help the patient tell his or her personal history, and models to deal with the illness.

Nurse: Then she asked me if I could pray. I said that she moved me by asking that, and that I sensed that she was scared. I told her that I recognized it and then I prayed the Lord's Prayer with her. This has moved me deeply and I also talked to my colleagues about it, who wondered if it was okay. To this woman it meant a lot.

Personal limits

Several nurses stressed the importance of not crossing one's personal limits. They believed that a process should only be started with the patient if the nurse is able to follow it through.

Nurse: A patient was brought to the IC during the night shift. Her condition had acutely deteriorated. A student brought her some mail the next day. She went over to the patient and out of the blue she

said: 'Do you want this, do you want to go on?' The patient softly replied 'No, no'. Then the student said: 'I have to leave now, to get back to the ward'. The patient said 'No, no, don't go'. The student was upset. She didn't know what to say.

Organization of care and multidisciplinary co-operation

Nurse referrals to or involving the hospital chaplains either occurred at a patient's request or were initiated by the nurse. Hospital chaplains said that nurses were often the driving force during multidisciplinary meetings when it came to making people aware of the relevance of spiritual aspects. Both nurses and hospital chaplains agreed that nurses raised a relatively small number of spiritual matters in these meetings.

Nurse: We had a 50-year-old man with lung cancer. He was back after 3 months, and it was a disappointment for him, going back to chemo. He was married, had four children. I thought: 'What should I do now?' I thought of spiritual care, but immediately wondered how I should bring it up. I always have the feeling that I should talk around it or else they wouldn't be willing to listen. But he needed it so much. I talked to him about it and he actually wanted this.

Different indications were mentioned for referrals to the spiritual advisor. Social work also focused on helping patients find a sense of purpose. In practice, this led to different referral behaviour by nurses. The referral seemed to depend on whether the particular discipline was present in the multidisciplinary meeting and on the nurse's interpretation of such issues. Nurses who associated these issues with unhealthy ways of coping were inclined to refer patients to a social worker. In the cooperation with physicians that occurred when decisions were made on treatment, nurses emphasized their role as 'the patient's advocate'.

Evaluation and reflection in the nursing team

The evaluation of spiritual aspects was confined to the nurse and the patient. When nurses experienced problems with the patient, they were more inclined to discuss it in team meetings. Team meetings occurred spontaneously and on a regular basis. Nurses considered these sessions to be very supportive. They created a mutual bond of understanding and trust, allowing the nurses to cope better with their work. It should be noted that spiritual aspects could not be discussed with all colleagues. Nurses knew which colleagues were open to it and they found the right person to talk to.

Nurse: I know which people I can easily talk to about it and which people I can't. It's the colleagues who also talk about it with patients

that I know are more open to it. I also know very well which people I shouldn't talk to about this, because they think it is out of line, or they do not see it as part of nursing.

Time

Patients saw that nurses were busy and understood that they had little time and attention for a conversation. They clearly defended the nurses on this. However, patients felt that time could sometimes be made available and some explicitly said that they were disappointed by the lack of attention. Nurses also admitted that they sometimes had little or no time for the patient and, hence, for spiritual aspects. They also realized that, in some cases, it is a matter of having to set the right priorities and choosing the right moment. Another point raised was that if nurses said they did not have time, they actually meant that they did not feel like talking (an avoidance mechanism).

Patient: Nurses do not have any time. They want to listen and then they sit on the side of your bed and then they have to leave again. They are open to it, but they don't have time to have a normal conversation.

Cultural aspects

There are different factors in the ward and hospital culture that may influence spiritual care. With respect to ward culture, the following were mentioned as having a positive influence: a close team, an outgoing culture, being well-informed about patients, a care vision based on personal attention to patients, a supervisor who has a positive attitude, and a good atmosphere within the team. With regard to hospital culture, there was an emphasis on factors that had a negative influence, such as: the corporate approach together with experiences of increasing commercialization, the dominance of medical-technical aspects that cause tensions between cure and care, the emphasis on evidence-based care. This gives people the impression that the human aspect of care is in danger.

Hospital chaplain: The organization is very much focused on efficiency, high-tech and controlling processes. These have produced wonderful results. But the relationship between humans has suffered.

Education

Little or no attention is paid during the basic training of nurses to explicit spiritual aspects. However, many nurses noted that the basic communication skills that are essential in

providing spiritual care were sufficiently taught at school. There was a need for additional training, involving topics such as spiritual conversation methods, personal spiritual awareness and how to apply this in professional care, information on spiritual/religious movements and the language and traditions that go with it, and finding a sense of purpose at work.

Discussion

These results suggest that attention to spiritual issues in the nursing process is present but not clear-cut; it seems very diverse and largely dependent on the personal expression of the individual nurse. These findings confirm the conclusion of Narayanasamy (2001) that the approach to spiritual care is apparently largely unsystematic and delivered haphazardly. This raises questions about the relationship between a nurse's professional responsibility and his or her personal convictions regarding spiritual care. The research also shows that the experiences and expectations of the nurse's role vary among patients, nurses and hospital chaplains. This matches the findings of Baldacchino (2003), who suggests that responsibility for spiritual care lies with the caregivers, but also with the patient's significant others (family, partner and own pastor). This seems to indicate a crucial role for the patient concerning the question of which spiritual needs play a role in his or her situation and who is to minister to those needs. Should we then accept that attention to spirituality within the nursing profession is simply a coincidence, as stated by a hospital chaplain in one of the interviews, or should we expect more from a nurse? Perhaps mixed focus groups with patients, nurses and hospital chaplains can shed some more light on this in future research.

This study indicates that the basic care activities that seem to form the essence of spiritual care are a nurse's presence, listening, respect. Many authors emphasize these aspects but also mention many other aspects of spiritual care (O'Brien 1998, McSherry 2000, Narayanasamy 2001, Taylor 2002). It seems, also, that nurses hardly know what their responsibility is with respect to spiritual care. In theory many of the expectations of nurses can be described in competencies for spiritual care that go far beyond basic skills (Leeuwen & Cusveller 2004). The main themes of the present study can be recognized as aspects of these competencies. However, the results of this research suggest that these aspects of spiritual care are poorly structurally embedded in nursing practice and barely form part of the professional competence of most nurses. According to Cone (1997), several stages should be introduced into the nurse's role in spiritual care, ranging from basic responsibility (listening and supporting practices)

to a real spiritual connection between nurse and patient, based on the same emotional and spiritual frame of reference. Not all nurses should be expected to operate at this latter level.

On the contrary, we suggest that, in addition to an inadequate context for spiritual care in nursing practice, other factors play a role as well (age, experience, upbringing, spiritual involvement, time and cultural aspects). This has also been recognized by McSherry (2000), who stated that nurses should give due thought and attention to the demands and pressures that many nurses encounter in their practice.

Another important reason for poor spiritual care by nurses in general may be the lack of education (McSherry & Draper 1997, Bush 1999, Greenstreet 1999, Narayanasamy 1999, Baldacchino 2003). Research studies show that nurses, after following nursing training programmes about spiritual care, experience more spiritual awareness and deepened relationships with patients and feel more competent in providing spiritual care (Groër *et al.* 1996, Bush 1999, Catanzaro & McMullen 2001, Fu-Jin *et al.* 2001, Hoover 2002, Jootun & Lyttle 2004). In agreement with Johnston Taylor (2005), we recommend that more studies be performed on the relationships between relevant variables (education, personal factors, cultural factors, etc.). They may generate insight into the effects of training programmes on the professional delivery of spiritual care.

Limitations of the study

This study has some limitations that may have affected the validity of the results. Firstly, it should be noted that a convenience sample was used. This might have biased the results and rules out generalizability of the results. Many of the participants were willing to participate because they were explicitly interested in the theme of spiritual care. Secondly, there were no participants with an Islamic background in the focus groups. This group forms a substantial part of the population in the Netherlands. It is important for further research to include this group to obtain a more representative view. Another aspect that should be considered is the relatively wide range of professional experience between nurses and the duration of the hospital stay of patients. This might have influenced the difference in experience with aspects of spiritual care.

The focus group method seemed to be adequate in answering the research questions. Despite measures to prevent people from dropping out, some did. It is not known whether this affected the outcome. The role of the discussion leader is also of vital importance. All participants must have their say during the discussions. In reality,

some participants are more dominant than others, which can affect the reliability and validity of the research. The trial interviews and the debriefings proved to be vitally important.

Conclusion

The research findings indicate that attention to spiritual issues in nursing care is not clear cut. The nurse's own spirituality may play an important role in paying attention to spiritual aspects in nursing practice. In addition to this 'personal factor', other factors seem to influence the provision of spiritual care (age, experience, spiritual involvement, upbringing, time, cultural factors and education). The participants in the focus groups also had different expectations of the nurse's role in spiritual care. It is suggested that future research should focus more on the factors that influence spiritual care in nursing, to clarify the nurses' professional responsibility in this respect.

Contributions

Study design: RvL, LJT, HJ, DP; data collection and analysis: RvL and manuscript preparation: RvL, LJT, HJ, DP.

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