Original Article

Nurse and Physician Barriers to Spiritual Care Provision at the End of Life

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Abstract

Context. Spiritual care (SC) from medical practitioners is infrequent at the end of life (EOL) despite national standards.

Objectives. The study aimed to describe nurses' and physicians' desire to provide SC to terminally ill patients and assess 11 potential SC barriers.

Methods. This was a survey-based, multisite study conducted from October 2008 through January 2009. All eligible oncology nurses and physicians at four Boston academic centers were approached for study participation; 339 nurses and physicians participated (response rate = 63%).

Results. Most nurses and physicians desire to provide SC within the setting of terminal illness (74% vs. 60%, respectively; $P = 0.002$); however, 40% of nurses/physicians provide SC less often than they desire. The most highly endorsed barriers were "lack of private space" for nurses and "lack of time" for physicians, but neither was associated with actual SC provision. Barriers that predicted less frequent SC for all medical professionals included inadequate training (nurses: odds ratio [OR] = 0.28, 95% confidence interval [CI] = 0.12–0.73, $P = 0.01$; physicians: OR = 0.49, 95% CI = 0.25–0.95, $P = 0.04$), "not my professional role" (nurses: OR = 0.21, 95% CI = 0.07–0.61, $P = 0.004$; physicians: OR = 0.35, 95% CI = 0.17–0.72, $P = 0.004$), and "power inequity with patient" (nurses: OR = 0.33, 95% CI = 0.12–0.87, $P = 0.03$; physicians: OR = 0.41, 95% CI = 0.21–0.78, $P = 0.007$). A minority of nurses and physicians (21% and 49%, $P = 0.003$, respectively) did not desire SC training. Those less likely to desire SC training reported lower self-ratings of spirituality (nurses: OR = 5.00, 95%

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CI = 1.82–12.50, $P = 0.002$; physicians: OR = 3.33, 95% CI = 1.82–5.88, $P < 0.001$) and male gender (physicians: OR = 3.03, 95% CI = 1.67–5.56, $P < 0.001$).

Conclusion. SC training is suggested to be critical to the provision of SC in accordance with national care quality standards. J Pain Symptom Manage 2014;48:400–410. © *2014 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Palliative care, religion, spirituality, spiritual care, hidden curriculum

Introduction

Spiritual care (SC) of patients at the end of life (EOL) has been identified as a core domain by the World Health Organization,[1] the National Consensus Project on Quality Palliative Care (NCPQPC),[2] and highlighted as an EOL priority by the Joint Commission.[3] The NCPQPC outlines the importance of an interdisciplinary medical team assessing patients' spiritual, religious, and existential dimensions of care and addressing spiritual needs.[2] Likewise, the Joint Commission requires health care institutions to provide quantifiable measures demonstrating "care and services that accommodate[s] patient's... spiritual EOL needs" and staff education concerning the unique needs of patients at the EOL.[3] These standards are grounded in an evidence base that outlines the importance of religion/spirituality (R/S) within an EOL experience[4] and the prominent spiritual needs encountered during life-threatening illness.[5–7] National and international guidelines also are based on prospective studies that have found associations between medical team spiritual support and 1) patient quality of life,[4,8,9] 2) decreased aggressive care at the EOL,[8] and 3) significantly higher costs when SC is absent.[10]

Although community clergy and hospital chaplains hold a central role in providing SC, the role of medical professionals is less clear. Consequently, empirical data grounding medical professional SC provision is needed. Despite palliative care guidelines[1–3] and research supporting the importance of its inclusion in EOL care, prior studies indicate that 6–26% of patients receive SC from their medical teams, revealing a gap between extant policies and current practice.[11–13] This gap does not appear to be primarily related to a lack of perceived importance of EOL SC by patients or clinicians as most patients, nurses, and physicians in an EOL care setting agree that R/S ought to be addressed by medical professionals.[13,14] Rather, barriers appear to be operating to limit SC provision despite a frequent awareness of its importance. Hence, to advance a holistic approach to palliative care provision that includes patient R/S, an understanding of medical professional barriers to SC provision is required. However, data exploring such barriers are limited. In studies of self-reported barriers to SC provision, reasons cited by nurses and physicians for infrequent SC provision include insufficient time to discuss R/S and personal discomfort with R/S.[14–17] Although illuminating as to potential barriers at play, these studies do not examine the relationship of these barriers to actual SC provision to patients. Furthermore, there are other putative barriers that require investigation, such as the asymmetry between the U.S. population and medical professionals in religious characteristics, including religious affiliation and self-reported religiosity and spirituality;[13,18] these factors may prompt medical professionals to avoid R/S issues, rather than risk creating discomfort or offense.[14,19,20] By understanding these barriers to SC, steps can be identified in how to best overcome them and facilitate the provision of SC to patients. Hence, critical to advancing SC as a central dimension of EOL care in accordance with national care quality standards[2,3] is an understanding of what factors limit actual provision of SC to patients at the EOL.

The Religion and Spirituality in Cancer Care study was designed to measure perceptions of SC barriers from the viewpoints of nurses

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