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Spiritual care for cardiac patients admitted to coronary care units in Gaza Strip: Cardiac patients' perception

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Abstract: Heart disease is the leading cause of death among the Palestinian people. Since there is a high correlation between stress and heart disease, preventing and relieving stress become a major concern for this group of patients. One of the approaches to reduce stress is the provision of spiritual care.

In spite of its importance, literature reveals not meeting spiritual needs of cardiac patients. Recently more attention is paid to spirituality in health care. As a result, many hospitals in the Western countries started to offer spiritual care to their clients. In Gaza Strip, there is no clear policy about providing spiritual care. Therefore, this study aimed to assess if spiritual care is provided to the hospitalized cardiac patients who live in Gaza Strip and who should provide this care.

The design for this study was a cross-sectional design. 279 cardiac patients (response rate of 99.29%) participated in this study. Results revealed that there is a severe shortage of providing spiritual care to cardiac patients and the majority of them (n=159, 57%) preferred that nurses to provide spiritual care to them.

As a conclusion, health policy makers need to pay more attention to this group of patients and need to adopt a spiritual care policy into the health care system, which will help to decrease their stress, length of hospitalization, and the cost of treatment.

Key words: Spiritual care, cardiac patients, perception

ملخص: يعتبر مرض القلب السبب الرئيس للوفاة في المجتمع الفلسطيني. و حيث أن هناك علاقة واضحة ما بين الضغوطات النفسية ومرض القلب ، يُصبح الحد من هذه الضغوطات أو منعها من أولى اهتمامات هذه المجموعةِ مِنْ المرضى. إن أحد أهم الوسائل التي من شأنها الحد من هذه الضغوطات أو منعها هو تقديم الرعايةِ الروحانية لهم.

بالرغم مِنْ أهمية تقديم الرعايةِ الروحانية ، تؤكد الدراسات السابقة عدم الاهتمام بالاحتياجات الروحانيةَ لمرضى القلب .مؤخراً بدأت العديد مِنْ المستشفيات في البلدانِ الغربيةِ بتقديم الرعاية الروحانيةِ لمرضاها. ولكن من الملاحظ أن قطاع غزة يفتقر إلى سياسة واضحة بخصوص تقديم العنايةِ الروحيةِ هذه الفئة من المرضى، لذا، هدّفتْ هذه الدراسةِ لاستيضاح مدى تقديم العنايةِ

الروحانيةِ لمرضى القلب المُدخَلين إلى مستشفيات قطاع غزة ومن هو الشخص الأنسب الذي مـــن الممكن أن يقدم هذه العنايةِ.

شملت هذه الدراسة 279 مريض من مرضى القلب الذين أدخلوا إلى أقسام العناية الفائقة. كَشفتْ النَتائجُ بأنّ هناك نَقْص حادّ في تقديم العنايةِ الروحانيةِ إلى هؤلاء المرضـــى و أن الأغلبيـــةِ مـــنهم فضّلوا بأن يقوم الممرضون و الممرضاتِ بتقديم مثل هذه العناية لهم.

Introduction

Heart disease was the leading cause of death among the Palestinian people. In 2010, deaths related to heart disease accounted for 23.5% of total deaths (figure 1) while cancer ranked second and accounted for 11.8% of all deaths reported in 2010 in Gaza Strip [1].

Cardiac patients are subject for more risky life and delayed recovery from heart attacks when they experience stress, hostility, anger, depression, and social isolation [2]. Therefore, they are more subject for repeated hospitalization. Rieck [3] argued that hospitalized patients are exposed to higher level of stress and anxiety than community-dwelling patients. Besides the stress and anxiety due to the disease they have, hospitalized patients are vulnerable to other stressors such as pain and other physical discomfort, dependence, dealing with strangers and unknown care givers, uncertainty, and invasion of privacy.

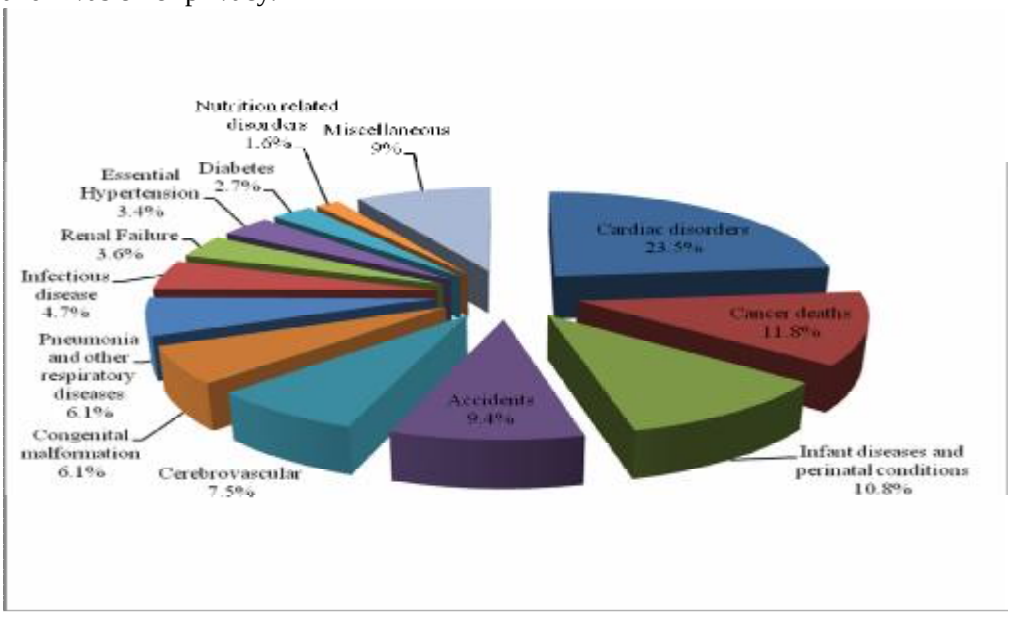

Figure 1: Leading causes of death in Gaza Strip. Source; Ministry of Health-Gaza: Health Information Center, 2011, Ministry of Health**,** PHIC, 2011)

Therefore, prevention and relief of suffering and alleviating stress become a major concern, especially at the end stage of heart failure [4]. With the increasing number of stressors and cardiac problems, it becomes necessary to introduce new trends of treatment along with the traditional medicine such as offering spiritual care to patients suffering from heart diseases.

Many studies examined the impact of spiritual care on health. For example, many clinicians have observed that optimistic, relaxed, and confident cardiac patients seem to come through the disease and other related procedures better than depressed patients. They also observed that that stress, anger, depression, and hostility impede the recovery from heart attacks [2]. At the clinical level, several studies emphasized that spirituality is associated with decreased anxiety and depression and increased capabilities in emotional coping [5-7](Mickley & Soeken, 1993; Tuck, 2001; Thoresen & Harris 2002). Congruently, Byrd [8] concluded from his experiment with 393 cardiac patients, that prayers promote healing. Therefore, it becomes evident that providing spiritual care to cardiac patients will help to decrease their stress, anxiety, and paint.

In spite of the positive impact of providing spiritual care to cardiac patients on their health, the literature revealed that assessing and meeting patients' spiritual needs are underestimated or neglected by health care providers [9].

From a different perspective, several studies explored and identified different spiritual needs of cardiac patients that were mostly not met by health care providers. Examples of these needs included regret regarding previous life style, a search for meaning of the current experience of the disease, and a search for hope for the future and regaining of optimism [10]. On the other hand, Park [11] concluded that patients with severe congestive heart failure had increased levels of spiritual struggle, daily spiritual experience, forgiveness, and religious life meaning. Knowing that patients diagnosed with heart disease have several un-met spiritual needs should motivate health care providers to work on meeting these needs as a part of patients care.

Health care providers, especially nurses and doctors, play an important role in reducing patients' anxiety and stress by providing emotional and spiritual care to their clients. For example, nurses who are available 24 hours for cardiac patients can convey acceptance, understanding, and caring about their patients and their problems while showing respect and acceptance about their personal decision-making capabilities [12].

Holistic philosophy is the core of health care. The holistic approach involves all aspects of human life. In order to provide holistic care, it is important for health care providers to include physical, psychological, socio-cultural, and spiritual dimensions in their interventions [13]. The World Health Organization (WHO) definition of health clearly included a spiritual aspect of health [14]. In spite of such assertion on the importance of including emotional and spiritual needs in the patients care, there is evidence in the literature that health care providers emphasize on meeting the physical, social, and psychological needs of their patients and that they seldom recognize their spiritual needs. Therefore, meeting patients' spiritual needs is often neglected [15-19].

Recently more attention was paid to spiritual care. It has drawn the attention of researchers, health care professionals and educators during the last 25 years [20]. The relationship between spirituality and illness is at the center of a growing body of literature [21]. As a result, in the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recognized that patients' "psychosocial, spiritual and cultural values affect how they respond to their care" [22, p. RI-8] and has focused on spirituality and emotional well-being as essential aspects of patient care. In practice, ignoring the spiritual needs means inability to acknowledge the totality and the holistic view of the human being [23]. Few decades ago, Carson [24] argued that holistic care can't exist without the spiritual aspect which gives the individuality and meaning of life and experiences of health and illness for the people. Such spirituality promotes the inner harmony and equilibrium of the human being [25]. Thus, neglecting or inadequate provision of spiritual care makes the claim of providing holistic care by health care providers questionable. Therefore, this study aims to assess if spiritual care is provided to hospitalized cardiac patients who live in Gaza Strip and to explore who should provide spiritual care to this group of patients.

Methodology

Design, Participants, and Sampling

The design for this study was a cross-sectional, exploratory design. The target population for this study was all adult (at least 18 years old) patients who live in Gaza Strip; diagnosed with a heart disease and were admitted to one of the three Coronary Care Units (CCU) available in Gaza Strip. Furthermore, the inclusion criteria included that patients should be hospitalized in the CCU for at least 24 hours and had passed the critical time and should be free from acute pain.

Data Collection

Data were collected by the principal researcher and another four trained data collectors. Participants were interviewed privately at the bedside, where they receive treatment. Initially, each potential participant was approached by the data collector who explained the purpose of the study and was asked to participate in the study. If he/she agreed, he/she was asked to sign a consent form to participate in this study.

Instrument

The Instrument (appendix one) used to collect data for this study was developed by Musa [18] and was tested for reliability and validity. It has two parts; a demographic sheet and the Spiritual Care Rating Scale (SCRS)-domain frequency. Few modifications were done at the demographic part to make the instrument suitable to be administered for the purpose of this study. The SCRS section measured participants' perceptions toward the frequency of providing spiritual care by health care providers and who was the most appropriate person to provide spiritual care to them. The items included in this part were organized in a sequence that reflected the spiritual assessment, interventions and outcomes [18]. It included 39 items that covered the frequency of performing assessment and interventions related to spiritual care. These items were answered using a six-point Likert Scale (1 = never, 2 = rarely, 3 = sometimes, 4 = often, 5 = always, and 6 = don't know). The SRCS was divided by Musa into two major subscales; Spiritual Care Assessment Rating Scale, Domain Frequency (SCARS-F) and the Spiritual Care Intervention Rating Scale, Domain Frequency (SCIRS-F) [18]. SCARS-F section contained 18 items and asked about the frequency of spiritual care assessment carried out by the health care providers while SCIRS-F section contained 21 items and asked participants about the frequency of spiritual care interventions provided by health care providers. The second section of this questionnaire asked the participants to identify the most appropriate person who, as they believed, can provide spiritual care for them during hospitalization.

Data Analysis

The Statistical Package for Social Science (SPSS), version 16, was used to compute and analyze the data. Data analysis procedures included basic descriptive statistics to describe the sample using descriptive statistics (means, ranges, standard deviations, and percentages) and frequency distribution tables and t test when appropriate.

Results and Discussion

Description of the Sample

A total of 281 potential participants, who met the inclusion criteria, were approached by the principal researcher and data collectors. Of them, only one patient refused to participate in this study. Another patient was excluded as he got tired during data collection, therefore the data collector decided not to continue in the interview. The total number of cardiac patients who filled the questionnaire was 279 patients out of 281 with a response rate of 99.29%. Of them, there were 164 male participants (58.78%) while the number of female patients was 115 participants (41.22%). The age of participants ranged between 24 and 93 years with a mean of 59.08 and a standard deviation of 12.865. The mean age of male patients was 56.99 while the mean age for female patients was 62.06 years.

Only 72 participants (25.8%, 16 male and 56 females) did not receive any education, while the rest had received some education. 18.3% of participants finished their high school and only 20.1% had some higher education. The majority of participants (n=179, 64.2%) are not working, retired (n=19, 6.8%), or incapable to work (n=21, 7.5%). The unemployment rate is more evident among female participants as only one participant had a full time job and another one had a part time job. The total number of female patients who didn't work is 113 participants with a percentage of 98.2%.

About half of the participants (49.46%, n=138) were admitted to Shifa Hospital; 99 participants (36.19%) were admitted to the CCU at Nasser Hospital, and 44 participants (14.38%) were admitted to the CCU at Shuhada Al-Aqsa Hospital. Participants were distributed over the five governorates of Gaza Strip. Table 1 illustrates the place of living for cardiac participants.

Frequency of Providing Spiritual Care

By examining the results of cardiac patients' responses for Spiritual Care Assessment Rating Scale items (items 1-18), which presented in table 2, it was noticed that the percentage of 'absolutely' not providing spiritual care assessment by health care providers ranged between 82.15 (item 5) and 98.9 % (item 13). But further examination of the results showed that the percentages of cardiac patients who reported that spiritual care assessment was absolutely not provided to them exceeded 90.7% in all items except four items (items 5 = 82.1%, item 8 = 88.5%, item 15 = 82.8%, and item 16 = 85.7%).

Spiritual care for cardiac patients admitted to coronary care

Table 1: Place of Living for Cardiac Participants

Place of living	All participants		Male Participants		Female Participants	
	Freq.	%	Freq.	%	Freq.	%
Northern Governorate	19	6.8	7	4.3	12	10.4
Gaza Governorate	112	40.1	61	37.2	51	44.3
Mid zone Governorate	46	16.5	37	22.6	9	7.8
Khanyounis Governorate	75	26.9	44	26.8	31	27.0
Rafah Governorate	27	9.7	15	9.1	12	10.4
Total	279	100.0	164	100.0	115	100.0

Table 2: Spiritual Care Assessment Rating Scale (Frequency & Percentage)

During your current hospitalization period. How often did the health care provider ask you		Absolutely	Rarely	Some-times	Often	Always	Don't know
About your spiritual/religious beliefs	Freq.	272	4	1	1	1	0
	%	97.5	1.4	0.4	0.4	0.4	0
About your relationship with God.	Freq.	261	12	4	2	0	0
	%	93.5	4.3	1.4	0.7	0	0
About your relationship with yourself, and significant others.	Freq.	266	8	4	1	0	0
	%	95.3	2.9	1.4	0.4	0	0
About your religious practices that you like to do	Freq.	252	20	6	1	0	0
	%	90.3	7.2	2.2	0.4	0	0
How your spiritual/religious practices (e.g., prayer, reading from Qur'an, and/or meditation) and beliefs help you to cope with the new situation after being diagnosed with cardiac disease?	Freq.	229	33	10	5	0	2
	%	82.1	11.8	3.6	1.8	0	0.7
About religious	Freq.	255	16	5	0	0	3

books, articles, or symbols that you like to have	%	91.4	5.7	1.8	0	0	1.1
About your favorite places to practice your religious activities	Freq.	268	12	1	0	0	2
	%	94.6	4.3	0.4	0	0	0.7
About changes in your spiritual/ religious practices, and feeling toward being diagnosed with a cardiac disease.	Freq.	247	20	10	0	0	2
	%	88.5	7.	3.6	0	0	0.7

Table 2 (Continued): Spiritual Care Assessment Rating Scale (Frequency & Percentage)

How they can help you to maintain your spiritual/ religious strength after being diagnosed with cardiac disease	Freq.	253	15	9	0	0	2
	%	90.7	5.4	3.2	0	0	0.7
What gives meaning and purpose to your life	Freq.	267	7	5	0	0	0
	%	95.7	2.5	1.8	0	0	0
About your life story and your future	Freq.	265	10	4	0	0	0
	%	95.0	3.6	1.4	0	0	0
About your sources of strengths and hope	Freq.	257	12	10	0	0	0
	%	92.1	4.3	3.6	0	0	0
About goals and wishes that you have not met them yet	Freq.	276	2	1	0	0	0
	%	98.9	0.7	0.4	0	0	0
About the	Freq.	261	7	5	1	4	1

most important relatives and/or friends to you	%	93.5	2.5	1.8	0.4	1.4	0.4
What brings joy, pleasure, and peace to your life	Freq.	231	21	23	1	1	2
	%	82.8	7.5	8.2	0.4	0.4	0.7
About your forgiveness for others and how to show forgiveness for yourself	Freq.	239	26	12	0	1	0
	%	85.7	9.3	4.3	0	0.4	0
About the most loving things that you do for others or receive from them	Freq.	255	20	2	0	1	0
	%	91.4	7.2	0.7	0	0.4	0
The appropriate time to ask and discuss with you spiritual/religious issues	Freq.	267	8	2	0	1	1
	%	95.7	2.9	0.7	0	0.4	0.4

Table 3: Spiritual Care Intervention Rating Scale (Frequency & Percentage)

		Absolutely	**Rarely**	**Some-times**	**Often**	**Always**	**Don't know**
Listen actively to you talk about your religious/ spiritual beliefs, strengths,	Freq.	185	24	63	1	2	3
	%	66.3	8.6	22.6	0.4	0.7	1.1

and your beliefs about God							
Give you the opportunity to talk about God and support coming from God	Freq.	174	36	9	21	35	4
	%	62.4	12.9	3.2	7.5	12.5	1.4
Listen actively to stories from your spiritual life	Freq.	182	59	14	11	3	2
	%	65.2	10.8	1.4	0.4	0.4	21.9
Offer to read from the Qur'an on you or to share prayer and meditation with you	Freq.	262	8	2	0	1	6
	%	93.9	2.9	0.7	0	0.4	2.2
Help you to have suitable place to pray, to read from Qur'an, or to meditate	Freq.	245	17	9	2	1	5
	%	87.8	6.1	3.2	0.7	0.4	1.8
Facilitate utilization of religious/spiritual resources available in	Freq.	231	31	7	1	2	7
	%	82.8	11.1	2.5	0.4	0.7	2.5

the hospital that you can use (e.g., common prayer room, the Holy Qur'an book, or other religious materials)							
Help you listen to religious programs on radio or TV if available	Freq.	261	13	0	1	1	3
	%	93.5	4.7	0	0.4	0.4	1.1
Give you the opportunity to participate in religious or spiritual events arranged on the ward (e.g., praying with others or visit other patients in the hospital)	Freq.	214	27	12	10	12	4
	%	76.7	9.7	4.3	3.6	4.3	1.4
Offer to discuss with you the difficulties of practicing prayer when sick	Freq.	252	18	5	1	2	1
	%	90.3	6.5	1.8	0.4	0.7	0.4
Arrange a visit by the hospital	Freq.	247	16	1	5	8	2
	%	88.5	5.7	0.4	1.8	2.9	0.7

imam to comfort and support you if requested by you							
Respect your privacy, dignity, religion, and religious and spiritual beliefs and rituals	Freq.	36	2	21	45	173	2
	%	12.9	0.7	7.5	16.1	62.0	0.7
Give your family the opportunity to visit you and to share prayer, reading from Qur'an, and meditation with you	Freq.	112	17	75	34	37	4
	%	40.1	6.1	26.9	12.2	13.3	1.4
Give your close friends the opportunity to visit you and to share prayer, reading from Qur' an, and meditation with you	Freq.	127	31	54	22	40	5
	%	45.5	11.1	19.4	7.9	14.3	1.8
Help you to become aware of meaning and purpose	Freq.	81	30	56	31	80	1
	%	29.0	10.8	20.1	11.1	28.7	0.4

of life in facing illness and suffering that have come with the cardiac disease							
Spend time with you giving comfort, support, and reassurance when needed	Freq.	94	45	95	27	18	0
	%	33.7	16.1	34.1	9.7	6.5	0
Create a feeling of kindness, cheerfulness, and intimacy when giving care to you	Freq.	43	42	100	49	45	0
	%	15.4	15.1	35.8	17.6	16.1	0
Help you to feel hopeful and to keep a positive outlook	Freq.	54	42	95	49	38	1
	%	19.4	15.1	34.1	17.6	13.6	0.4
Help you to complete unfinished business or activities	Freq.	196	39	27	7	10	0
	%	70.3	14.0	9.7	2.5	3.6	0
Help you in listening to music or practicing another art if requested	Freq.	14.8	20	5	3	2	1
	%	88.9	7.2	1.8	1.1	o.7	0.4

by you							
Make you laugh or introduce appropriate humor to you	Freq.	88	60	91	31	8	1
	%	31.5	21.5	32.6	11.1	2.9	0.4
Hold your hand or put his hand over your shoulders to give you support and reassurance	Freq.	45	40	100	55	38	0
	%	16.1	14.3	35.8	19.7	13.6	0

By examining the frequencies and percentages of the responses of cardiac participants for Spiritual Care Intervention Rating Scale items (items 19-39), presented in table 3, it was noticed that participants' responses to the items of the questionnaire had a great variances. For example, the percentages for the choice "Never" ranged from 12.9% for item 29 to 93.9% for item 22.

To better explain the results, the cardiac patients' responses were converted into scores according to the following scale: 'never' = 0, 'rarely' = 25, 'sometimes' = 50, often = 75, 'always' = 100. The mean and standard deviation for each item of the Spiritual Care Assessment Rating Scale and for Spiritual Care Intervention Rating Scale was calculated and presented in tables 4 and 5.

As it is noticed from table 4, the minimum score for each item of the Spiritual Care Assessment Rating Scale was zero, the maximum scores ranged between 50 &100 for the 18 items. The mean score for performing spiritual assessment by health care providers ranged between 0.36 (item number 13) and 6.30 (item number 15) while the mean of providing spiritual care assessment items (items 1-18) was 2.58 and standard deviation 5.576 (table 6). Such very low scores reflect the lack of providing spiritual assessment by health care providers to cardiac patients.

Table 4: Spiritual Care Assessment Rating Scale Scores (Descriptive Statistics)

	Mean	Std. Deviation
About your spiritual/religious beliefs	1.16	8.534
About your relationship with God.	2.33	9.898
About your relationship with yourself, and significant others.	1.70	8.442
About your religious practices that you like to do	3.14	10.454
How your spiritual/religious practices (e.g., prayer, reading from Qur'an, and/or meditation) and beliefs help you to cope with the new situation after being diagnosed with cardiac disease?	5.96	14.918
About religious books, articles, or symbols that you like to have	2.36	8.732
About your favorite places to practice your religious activities	1.26	5.885
About changes in your spiritual/ religious practices, and feeling toward being diagnosed with a cardiac disease.	3.61	11.081
How they can help you to maintain your spiritual/religious strength after being diagnosed with cardiac disease	2.98	10.324
What gives meaning and purpose to your life	1.52	7.640
About your life story and your future	1.61	7.473
About your sources of strengths and hope	2.87	10.424
About goals and wishes that you have not met them yet	0.36	3.655
About the most important relatives and/or friends to you	3.24	14.667
What brings joy, pleasure, and peace to your life	6.30	15.346
About your forgiveness for others and how to show forgiveness for yourself	4.84	13.373
About the most loving things that you do for others or receive from them	2.51	9.623

The appropriate time to ask and discuss with you spiritual/religious issues	1.44	8.374
All items	2.58	5.576

Similarly, by examining table 5, it was noticed that both the minimum and the maximum scores for each item of the Spiritual Care Intervention Rating Scale were zero to 100. The mean score for performing spiritual intervention by health care providers ranged between 1.47 (item number 22) and 78.61 (item number 29) while the mean of providing spiritual care intervention items (items 19-39) was 24.68 and standard deviation of 12.134 (table 6). Such very low score reflects the lack of providing spiritual intervention by health care providers to cardiac patients.

Table 6 summarizes the means and standard deviations for all assessment items (items 1-18), all intervention items (items 19-39), and the total of all items (assessment and intervention items, items 1-39). The mean of Spiritual Care Assessment Rating Scale is 2.58 (Standard Deviation 5.576), the mean of Spiritual Care intervention Rating Scale is 24.68 (Standard Deviation 12.134), while the mean for both Assessment and Intervention Scales is 14.54 (Standard Deviation 7.573). The three means reflect the severe shortage of providing spiritual care by health care providers to cardiac patients in Gaza Strip.

Table 5: **Spiritual Care Interventions Rating Scale Scores**

	Mean	**Std. Deviation**
Listen actively to you talk about your religious/spiritual beliefs, strengths, and your beliefs about God	14.64	22.540
Give you the opportunity to talk about God and support coming from God	23.36	36.399
Listen actively to stories from your spiritual life	13.91	23.294
Offer to read from the Qur'an on you or to share prayer and meditation with you	1.47	8.449
Help you to have suitable place to pray, to read from Qur'an, or to meditate	4.11	13.500
Facilitate utilization of religious/spiritual resources available in the hospital that you can use (e.g., common prayer room, the Holy Qur'an book, or other religious materials)	5.15	14.284
Help you listen to religious programs on radio or TV if available	1.81	9.114

Give you the opportunity to participate in religious or spiritual events arranged on the ward (e.g., praying with others or visit other patients in the hospital)	11.73	26.006
Offer to discuss with you the difficulties of practicing prayer when sick	3.51	12.880
Arrange a visit by the hospital *imam* to comfort and support you if requested by you	5.87	20.063
Respect your privacy, dignity, religion, and religious and spiritual beliefs and rituals	78.61	34.323
Give your family the opportunity to visit you and to share prayer, reading from Qur'an, and meditation with you	38.36	36.704
Give your close friends the opportunity to visit you and to share prayer, reading from Qur' an, and meditation with you	33.30	37.025
Help you to become aware of meaning and purpose of life in facing illness and suffering that have come with the cardiac disease	49.91	39.884
Spend time with you giving comfort, support, and reassurance when needed	34.77	30.597
Create a feeling of kindness, cheerfulness, and intimacy when giving care to you	50.99	31.543
Help you to feel hopeful and to keep a positive outlook	47.75	32.103
Help you to complete unfinished business or activities	13.80	25.313
Help you in listening to music or practicing another art if requested by you	4.23	14.333
Make you laugh or introduce appropriate humor to you	33.00	27.961
Hold your hand or put his hand over your shoulders to give you support and reassurance	50.09	31.039
All items	24.68	12.134

Reporting on spiritual needs of patients was evident in the literature in the last years. Many studies were conducted to investigate spiritual needs of several categories of patients including patients diagnosed with cancer, HIV, and heart disease. Some of these studies focused on identifying the spiritual needs of

Table 6: Summary of descriptive statistics of Assessment and interventions scales items.

	Minimum	Maximum	Mean	Std. Deviation
Spiritual Care Assessment Rating Scale	.00	38.16	2.58	5.576
Spiritual Care Interventions Rating Scale	.00	80.95	24.68	12.134
Both Assessment & interventions scales	.00	51.28	14.54	7.573

different patients categories [19, 20], while others focused on exploring the frequency of providing spiritual care to several categories of patients [15-19, 28-30].

In a study conducted by Fagerström, Erikson, & Engberg [31], the authors reported that in spite that many patients found it was difficult to talk about their spiritual needs, participants reported the following spiritual needs: need for respecting their humanity, to be seen and understood, to be welcomed, giving and receiving love, to experience contact and closeness, and to feel that they have a meaning in life.

In a similar study, Taylor [27], using a semi-structured interviews, explored the spiritual needs of 28 cancer patients and their family caregivers. The results of the study revealed seven categories of spiritual needs. These categories "included needs associated with relating to an Ultimate Other; the need for positivity, hope, and gratitude; the need to give and receive love; the need to review beliefs, the need to have meaning; and needs related to religiosity and preparation for death" (p. 260). Furthermore, Taylor [27] reported that the most important spiritual needs of cancer patients were "being positive, loving others, finding meaning, and relating to God" (p.279). Spiritual needs that were reported as the least important included the need "to ask 'why' questions and preparing for dying" [27, p.729]. From a different perspective, Narayanasamy et al. [27] found out that the most spiritual needs reported by nurses who cared for elderly people were the needs for searching for respect & privacy; healing or searching for meaning and purpose; seeking connectedness, comfort and reassurance; help to complete unfinished business; help to connect; listen to their concerns, comfort and reassurance; assistance in religious practice; and listen to patients' concerns.

Spiritual care for cardiac patients admitted to coronary care

Other studies focused to investigate how often spiritual needs were provided by health care providers to several groups of patients. In a study that aimed to "understand, from the perspective of cancer patients and their family caregivers, what spiritual care is wanted from nurses" [17, p. 260], the researchers observed that the majority (more than 50%) of patients responded with either strongly disagree or disagree for 15 items out of the 20 itmes included in the list. This result reflected the shortage of providing spiritual care by nurses. In another study conducted by Murray et al. [20] who intervied 149 of terinally ill patients and family members who took care of them, participants reported that there often unment spiritual needs of the patients and the care givers by their general practitioners. The results of this study is congruent with these literature. In another study conducted by Kuuppelomäki [15] that included 328 nurses participants reported that they were short in their wellingness and readiness to provide spritual care to terminally ill patients. Furthermore, half of the nurses included in the study reported that they rarely offered spritual care and support to their patients. On the same vien, on an online survey of 4054 British nurses surveyed by McSherry and Jamieson [19], only 5.3% of nurse mentioned that they always met their patients' spiritual needs, 92.2% stated that 'sometimes' they met their patients' needs, and 2.5% felt that they never met their patients' spiritual needs.

Dixon et al. [28] found that the majority of 1124 cardiac patients reported unmet spirtual needs after discharge from the hospital. On the other hand, after an extensive review of literature, Clark et al. [29] concluded that the majority of hospitalized patients expereinced some form of emotional and spritual distress and that helath care providers didn't wholly address these needs. Similarly Feudtner et al. [30] reported that staff met about 60% of the spiritual needs of hospitalized children and their families. Similar low percentages about providing spiritual care were reported in the literature [15, 16, 18, 32].

As it is evdent, in spite that several studies identified spritual needs of patients, the results of this study along with the results of other several studies reported on the lack of providing spiritual care to different groups of patients. Such results should bring to attention why spirtual care is not provided, what are the barriers to providing spritual care, and what can be dome to overcome these barriers to provide spritual care to these groups of patients.

Who Should Provide Spiritual Care

In response to the question "who is the most appropriate person to provide spiritual care," the majority of the participants (n=159, 57%) thought that nurses were the most appropriate persons to provide spiritual care to them. Family members ranked second (n=72, 25.8%), and Imam (clergy) (n=27, 9.7%) ranked third. While eleven participants (3.9%) preferred that no one to offer spiritual care to them, only six participants (2.2%) preferred that physicians to provide spiritual care to them (Table 7).

The results reported by the participants were expected. This is because nurses are available to them and reachable 24 hours a day. On the other hand,

Table 7: The most appropriate person to provide spiritual care to cardiac patients.

Who is to provide spiritual care	Frequency	Percent
Nurses	159	57.0
Family Members	72	25.8
Imam (Clergy)	27	9.7
No one	11	3.9
Doctors	6	2.2
Friends	3	1.1
Others	1	.4
Physiotherapists	0	0
Total	279	100.0

physicians usually spend a very little time with them during the day. Family members are also not available for most of the day as the visiting policy allows for a maximum of two visitors for each patient for few minutes twice a day.

By examining the literature, it was found that several studies tackled this topic and wondered 'who should provide spiritual care?' Among those who were reported in the literature as the most resourceful persons to patients with spiritual care and spiritual support were nurses along with family members, physicians, friends, and clergy men [18, 33-38]. On the other hand, the results of these studies showed different preferences by participants about who is the most appropriate person to provide spiritual care to them. For example, Taylor [26] reported that family members, friends, and clergy were the most convenient people to provide patients with spiritual care. Similarly, in Reed's

[39] study, nurses came behind family members, friends, and clergy and before physicians as the most appropriate people to provide them with spiritual care and spiritual support; which is consistent with this study's result. Different results were reported by participants of King and Bushwick's [40] study as 77% of hospitalized patients reported that they would like their physicians to meet their spiritual care needs; and this doesn't agree with the result of this study.

From a different perspective, some studies sought the perception of nurses about who should provide spiritual care. For example, nurses participated McSherry and Jamieson [19] and Kristeller, Zumbrun, & Schilling [41] perceived themselves to be in the front position to provide spiritual care to their patients. On the other hand, Pronk [35] advocated that physicians are in a good position to provide spiritual care to terminally ill as he mentioned that "closeness and confidentiality implicit in the doctor patient relationship puts the doctor in a privileged position, and the patient may welcome openness to discussions of a spiritual nature' (pg. 421). On the other hand, Sawatzky and Pesut [36] argued that intimacy and trust relationship that develops between patients and nurses which is fostered by the care provided by nurses 24 hours a day allows nurses to be in a good position to provide spiritual care and spiritual support to their patients. In the same vein, Chan [42] added that "nurses have the unique task of working with patients at various and multiple points throughout their life journeys. Often, they encounter patients on the 'rough parts of the trail', when spiritual care becomes one of the major components in holistic care" (p. 2129). Such availability besides the patients, may give them the advantage of being an excellent source for spiritual assistance at the time it is needed. These results are not different than the result of this study.

Furthermore, the results of the responses of cardiac patients of this study are consistent with Musa's study [18]. Musa conducted a similar study in Jordan, which shares most of the characteristics of the Palestinian population in religion, culture, and demographics. The majority of his participants (90.5%) reported that nurses were the most appropriate persons to provide spiritual care to them. Table 8 illustrates a comparison of the participants' responses of this study and responses of participants of Musa's study about the most appropriate person to provide spiritual care for cardiac patient.

The variances in the responses to the question 'who should provide spiritual care' are not unique to the results of this study. This was posed by many authors without coming to a common agreement about who should provide

spiritual care. Often, in the Western countries, hospitals have assigned the responsibility of providing spiritual care to pastoral teams and chaplains, but this post is not available in the health care system in Gaza Strip. Vande

Table 8: The most appropriate person to provide spiritual care to cardiac patients: a comparison of results of this study and Musa's (2007) study

Who is to provide spiritual care	This study		Musa's study	
	Frequency	Percent	Frequency	Percent
Nurses	159	57.0	57	90.5
Family Members	72	25.8	3	4.8
Imam (Clergy)	27	9.7	2	3.2
No one	11	3.9	0	0
Doctors	6	2.2	1	1.6
Friends	3	1.1	0	0
Others	1	.4	0	0
Physiotherapists	0	0	0	0
Total	279	100.0	63	100

Creek & Lyon [43] argued that chaplains can provide in-depth spiritual care to patients, which can result in improved satisfaction and emotional comfort. Similarly, Hunt, Cobb, Keeley, & Ahmedzai [44] argued that chaplains are the specialist professionals who are prepared to provide spiritual care, therefore, when clinicians face a complex spirituality-related situation, they need to refer them to the specialists, the chaplains.

In spite that Vande Creek [45] emphasized the rule of chaplains in providing spiritual care, he added that chaplains should collaborate with nurses and physicians and other staff in providing spiritual care. Therefore, health care providers need to know when and at what circumstances to refer their patient to pastoral care [39]. Similiarly, Clark et al. [29] argued that health care providers including nurses, doctors, clinicians, and other care givers have important roles in providing spiritual care.

As it is evident in the literature, spiritual care can be provided by multiple health care professionals. McSherry and Jamieson [19] advocated for the idea of having a multidisciplinary emotional and spiritual care team. According to McSherry and Jamieson [12], the team will be responsible about coordinating

resources, interventions, communications, and organize learning and training for staff to improve their abilities to meet the spiritual needs of their patients.

Conclusion

While the literature emphasizes the importance of providing spiritual care to different groups of patients and how it may reduce the stress level and contribute to improving their health and will-being, the results of this study revealed that there is a severe shortage of providing spiritual care to cardiac patients admitted to CCU's of Gaza Strip's hospitals. This is a crucial signal to health care policy makers to work in adopting a policy related to integrating spiritual care policy in the care of cardiac patients and other groups of patients diagnosed with different diagnoses. Hospital administrators need to provide training to health care providers to help them in improving their skills to assess and meet their clients' spiritual needs. Finally, health educators need to include teaching spiritual care into their curricula for future health care providers.

References

[1] Annual report 2010: Mortality rate report in Gaza for 2010: http://www.moh.gov.ps/portal/attachments/article/4163/Mortality%20report%202010.pdf.

[2] Harvard Men's Health Watch, Mind and body: Do music, imagery, touch, or prayer improve cardiac care? Harvard Men's Health Watch, Vol. 11, No. 5, p: 6-7. (2006).

[3] Rieck, S. B., **The relationship between the spiritual dimension of the nurse-patient relationship and patient wellbeing.** Unpublished dissertation, College of Nursing, the University of Arizona, Arizona (2000).

[4] Oates, L. Providing spiritual care in end-stage cardiac failure. International Journal of Palliative Nursing, Vol. 10, No. 10, P: 485-490 (2004).

[5] Mickley, J., & Soeken K., Religiousness and hope in Hispanic- and Anglo-American women with breast cancer. Oncology Nursing Forum. Vol. 20, No. 8, P: 1171–1177 (1993).

[6] Thoresen, C. E., & Harris, A., H., Spirituality and health: What's the evidence and what's needed? Annals of Behavioral Medicine. Vol. 24, No. 1, P: 3–13 (2002)..

[7] Tuck, I., McCain, N.L., & Elswick, R.K., Spirituality and psychosocial factors in persons living with HIV. Journal of Advanced Nursing. Vol. 33, No. 6, P:776-783 (2001).

[8] Byrd, R. C., Positive therapeutic effects of intercessory prayer in a coronary care unit population. Southern Medical Journal. Vo. 81, No. 7, P: 826-829 (1988).

[9] Oldnall, A., A critical analysis of nursing: meeting the spiritual needs of patients. Journal of Advanced Nursing. Vol. 23, No. 1, P: 138-144 (1996).

[10] Westlake, C, Dracup, K., The Role of spirituality in Adjustment of Patients with Advanced Heart Failure: A qualitative analysis. Progress in Cardiovascular Nursing. Vol. 16, No. 3, P: 119-125 (2001).

[11] Park, C. L., Estimated longevity and changes in spirituality in the context of advanced congestive heart failure. Palliative and Supportive Care. Vol. 6, No. 1, P: 3-11 (2008).

[12] Barry, P. D., **Psychosocial nursing; Care of physically ill patients and their families.** Lippincott, Philadelphia, (1996).

[13] Timby, B. K., **Fundamentals concepts and skills for nurses.** Lippincott Williams & WilkinsPhiladelphia, (2009).

[14] Review the constitution of the World Health Organization: report of the executive board special group. http://www.who.int/genomics/publications/governance/eb/eb080/en/.

[15] Kuuppelomäki, M., Spiritual support for terminally ill patients: nursing staff assessments. Journal of Clinical Nursing, Vol. [10], No. 5, P: 660-670. (2001).

[16] Stranahan, S., Spiritual perception, attitudes about spiritual care, and spiritual care practices among nurse practitioners. Western Journal of Nursing Research, Vol. 23, No. 1, P: 90-104 (2001).

[17] Taylor, E., & Mamier, I., Spiritual care nursing: What cancer patients and family care givers want. Journal of Advanced Nursing, Vol. 49, No. 3, P: 260-267 (2005).

[18] Musa, A., **Spiritual nursing care and spiritual wellbeing of hospitalized patients following coronary artery bypass grafting surgery**. Unpublished doctoral dissertation, University of Essex, Colchester, UK, (2007).

[19] McSherry, W., & Jamieson, S., An online survey of nurses' perceptions of spirituality and spiritual care. Journal of Clinical Nursing, Vol. 20, P: 1757–1767 (2011).
[20] Murray, S. A., Kendall, M., Boyd, K., Worth, A., & Benton, T. F., General practitioners and their possible role in providing spiritual care: a qualitative study, British Journal of General Practice, Vol. 53, 957-959 (2003).
[21] Kaye, J., & Raghavan, S., Spirituality in disability and illness. Journal of Religion and Health, Vol. 41, No. 3, P: 231-242 (2002).
[22] Joint Commission Resources, **Comprehensive accreditation manual for hospitals: The Official handbook.** Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, (2003)-.
[23] Gray, D.P., Steele, R., Sweeney, K., and Evans, P., Generalists in medicine: general practice is medicine with a human face, British Medical Journal, Vol. 308, P: 486 -487 (1994).
[24] Carson, V. B., **Spiritual development across the life span.** W. B. Saunders, Philadelphia, (1989).
[25] McSherry, W., Nurses' perceptions of spirituality and spiritual care, Nursing Standard, Vol. 13, No, 4, P: 36–40 (1998).
[26] Narayanasamy, A., Clissett, P., Parumal, L. Thompson. D., Annasamy, S., & Edge. R., Responses to the spiritual needs of older people, Journal of Advanced Nursing, Vol. 48, No. 1, P: 6–16 (2004).
[27] Taylor, E. J., Prevalence and associated factors of spiritual needs among patients with cancer and family caregivers, Oncology Nursing Forum, Vol. 33, No. 4, P: 729-35 (2006).
[28] Dixon, T.; Lim, L.; Powell, H.; & Fisher, J. D., Psychosocial experiences of cardiac patients in early recovery: a community-based study, Journal of Advanced Nursing, Vol. 31, No. 6, P: 1368-1375 (2000).
[29] Clark, P. A., Drain, M.; & Malone, M.P., Addressing patients' emotional and spiritual needs, Joint Commission Journal on Quality and Safety, Vol. 29, No. 12, P: 659-670 (2003).
[30] Feudtner, C., Haney, J., & Dimmers, M. A., Spiritual care needs of hospitalized children and their families: A national survey of pastoral care providers' perceptions, Pediatrics, Vol. 111, No. 1, P: 67-72 (2003).
[31] Fagerström, L.; Erikson, K.; & Engberg, I. B., The patient's perceived caring needs: measuring the unmeasurable, International Journal of Nursing Practice, Vol. 5, No. 4, P: 199-208 (1999).

[32] Taylor, E. J., Amenta, M., & Highfield, M., Spiritual care practices of oncology nurses, Oncology Nursing Forum, Vol. 22, No. 1, P: 31-39 (1995).
[33] Taylor, E. J., **Spiritual care: nursing theory, research, and practice**. Uper Saddle River, New jersy (2002).
[34] Handzo, G., Koenig, H., Spiritual care: Whose job is it anyway?, Southern Medical Journal, Vol. 97, No. 12, P: 1242-1244. (2004).
[35] Pronk, K., Role of the doctor in relieving spiritual distress at the end of life, American Journal of Hospice & Palliative Medicine, Vol. 22, No. 6, P: 419-425 (2005).
[36] Sawatzky, R., Pesut, B., Attributes of spiritual care in nursing practice, Journal of Holistic Nursing, Vol. 23, No, 1, P: 19-33 (2005).
[37] Taylor, E. J., What have we learned from Spiritual Care Research?, Journal of Christian Nursing, Vol. 22, No. 1, P: 22-29 (2005).
[38] Baldacchino, D. R., Nursing competencies for spiritual care, Journal of Clinical Nursing, Vol. 15, No. 7, P: 885–896 (2006).
[39] Reed, P., Preferences for spiritually related nursing interventions among terminally ill and nonterminally ill hospitalized adults and well adults, Applied Nursing research, Vol. 4, No. 3, P: 122-128 (1991).
[40] King, D. E, Bushwick, B., Beliefs and attitudes of hospital inpatients about faith healing and prayer, Journal of Family Practice, Vol. 39, No. 4, P: 349-352 (1994).
[41] Kristeller, J. L., Zumbrun, C. S. & Schilling, R. F., 'I would if I could': how oncologists and oncology nurses address spiritual distress in cancer patients, Psycho-Oncology, Vol. 8, No. 5, P: 451–458 (1999).
[42] Chan, M. F., Factors affecting nursing staff in practising spiritual care, Journal of Clinical Nursing, Vol. 19, No. 15, P: 2128–2136 (2008).
[43] Vande Creek, L. & Lyon, M. A., Ministry of hospital chaplains: Patient satisfaction, Journal of Health Care Chaplain, Vol. 6, No. 2, P: 1-61 (1997).
[44] Hunt, J., Cobb, M., Keeley,V.L., Ahmedzai, S.M., The quality of spiritual care-developing a standard, International Journal of Palliative Nursing, Vol. 9, No. 5, P: 208–215 (2003).
[45] Vande Creek, L., Collaboration between nurses and chaplains for spiritual caregiving. Seminars in Oncolgy Nursing, Vo. 13, No. 4, 279-280 (1997).
[46] Astrow, A.B., Puchalski, C.M., & Sulmasy, D.P., Religion, spirituality, and health care: social, ethical, and practical considerations, The American Journal of Medicine,Vol. 110, No. 4, P: 283–287 (2001).