Published in final edited form as:
Support Care Cancer. 2013 November ; 21(11): 2991–2998. doi:10.1007/s00520-013-1863-y.

Surprising results regarding MASCC members' beliefs about spiritual care

Lois M. Ramondetta, MD[1], **Charlotte Sun, DrPH**[1], **Antonella Surbone, MD, Ph.D.**[2], **Ian Olver, AM**[3], **Carla Ripamonti, MD**[4], **Tatsuya Konishi**[5], **Lea Baider, PhD**[6], and **Judith Johnson, PhD, RN**[7]

[1]Department of Gynecologic Oncology and Reproductive Medicine, The University of Texas MD Anderson Cancer Center, Houston, TX

[2]Department of Medicine, New York University, New York, NY

[3]Cancer Council Australia, Sidney, Australia

[4]Supportive Care Cancer Unit, IRCCS Foundation, National Cancer Institute of Milano, Milano, Italy

[5]Medical Corporation Soshukai, Miyagi, Japan

[6]Department of Medical Psychology, Sharett Institute of Clinical Oncology and Radiology, Hadassah University Hospital, Jerusalem, Israel

[7]HealthQuest, Minneapolis, MN

Abstract

Background—The purpose of the study was to better understand the practice and meaning of spiritual care among cancer care professionals and ultimately provide a rationale for developing internationally focused spiritual care guidelines.

Methods—We developed a 16-question survey to assess the spiritual care practices. We sent 635 MASCC members 4 e-mails each inviting them to complete the survey via an online survey service. Demographic information was collected. The results were tabulated, and summary statistics were used to describe the results.

Results—Two hundred seventy-one MASCC members (42.7%) from 41 countries completed the survey. Of the respondents, 50.5% were age ≤50 years, 161 (59.4%) were women and 123 (45.4%) had ≥20 years of cancer care experience. The two most common definitions of spiritual care the respondents specified were “offering emotional support as part of addressing psychosocial needs” (49.8%) and “alleviating spiritual/existential pain/suffering” (42.4%). Whether respondents considered themselves to be “spiritual” correlated with how they rated the importance of spiritual care ($P \leq 0.001$). One hundred six respondents (39.1%) reported that they believe it is their role to explore the spiritual concerns of their cancer patients, and 33 respondents (12.2%) reported that they do not feel it is their role. Ninety-one respondents (33.6%) reported that they seldom provide adequate spiritual care, and 71 respondents (26.2%) reported that they did not feel they could adequately provide spiritual care.

Correspondance: Lois M. Ramondetta, M.D., Department of Gynecologic Oncology and Reproductive Medicine, Unit 1362, The University of Texas MD Anderson Cancer Center, 1155 Herman Pressler, Houston, TX 77030. Telephone: 713-745-0307; Fax: 713-792-7586; lramonde@mdanderson.org.

Conflict of Interest

All authors agree there are no financial relationships with the organization sponsoring this research. The authors have full control of all primary data and agree to allow the journal to review this data if requested.

Conclusions—The majority of MASCC members who completed the survey reported that spiritual care plays an important role in the total care of cancer patients, but few respondents from this supportive care focused organization actually provide spiritual care. However, in order to be able to provide a rationale for developing spiritual care guidelines, we need to understand how to emphasize the importance of spiritual care and at minimum, train MASCC members to triage patients for spiritual crises.

Keywords

Spiritual Care; Supportive Care; MASCC; Spiritual Assessment

Introduction

In 2009, Puchalsky et al. [1] first defined “spiritual care” in medicine and differentiated physicians’, nurses’, and social workers’ roles in delivering spiritual care from those of clergy and psychiatrists. The authors recommended that every patient should at least undergo “spiritual triage” to determine whether the patient is experiencing a spiritual crisis and/or negative religious coping that could interfere with the patient’s ability to adjust to a cancer diagnosis. Puchalsky et al. defined spirituality as “the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”

Spiritual well-being and spiritual care is important to individuals with a cancer diagnosis. In cancer patients, a sense of spiritual well-being has been associated with lower levels of anxiety and depression, a smaller sense of isolation, easier adjustment to the effects of cancer and its treatment, and an increased ability to enjoy life during treatment [2–4]. Patients with advanced cancer who received less spiritual care than desired reported having significantly more depressive symptoms and less meaning and peace than patients with advanced cancer who received the spiritual care they desired (P=0.042) [5]. Further, patients with improved spiritual well-being appear to have improved pain control. In contrast, negative religious coping has been associated with distress, confusion, depression, and poor quality of life in cancer patients [6] [7].

At least 65% of clinicians do not take a spiritual history [8, 9]. The reasons why some physicians do not address their patients’ spiritual care have been only minimally explored. For many care givers, reasons for not taking a spiritual history might include a lack of training, a lack of time, unrealistic survival expectations, and/or discomfort with one’s own existential beliefs [8] [10] [11].

While the need to define an appropriate application for spiritual care seems intuitive, much of the literature about addressing patients’ spiritual care originates from monotheistic, Judeo-Christian Western populations. Only limited knowledge of the international practice and implementation of spiritual care exists to-date [12]. We sought to develop such a definition to gain a broader more inclusive understanding of physicians’ understanding of patients’ spiritual care needs and improve our approach to providing spiritual care to patients. Here, we present the findings of a spiritual care survey developed by the Psychosocial Oncology Study-Work Group of the Multinational Association of Supportive Care in Cancer (MASCC), an international, multidisciplinary organization whose members represent more than 60 countries on 5 continents, to ascertain the spiritual care practices of MASCC members. Because of the unique multicultural character of this organization, we felt we were uniquely positioned to develop a more global definition and understanding of

the international practice and implementation of spiritual care. This publication is the result of a survey developed by the MASCC Psychosocial Oncology Study-Work group.

Methods

This study was approved by The University of Texas MD Anderson Cancer Center's Institutional Review Board.

The Psychosocial Study Group developed a 16-question survey that asked participants about their experience with and perceptions of spiritual care and vetted it over 2 annual meetings in 2009 and 2010. In order to gather as many respondents as possible, we sent all 635 MASCC members 4 e-mails between February 2 and 22, 2011, inviting them to complete the survey via SurveyMonkey, an online survey service [13]. The e-mails included an introductory letter assuring the potential participants that their identities and responses to the survey would remain confidential and that their completion of the survey would constitute their consent to be included in the study. They were also reminded not to take the survey more than one time. Demographic information collected during the survey included participants' age, gender, country of birth, country of practice, discipline, and years of experience. The demographics were tabulated, and summary statistics were used to describe results. Investigators involved in database management and statistical analyses did not have access to the identities of the study participants. Chi-square tests were used to compare group differences for categorical variables. *P* values <.05 were considered statistically significant. SPSS version 17.0 (SPSS Inc, Chicago) was used to analyze the data.

Results

Of the 635 MASCC members we invited to participate in the study, 271 members (42.7%) from 41 countries completed the survey. The respondents' demographic characteristics are given in Table 1. Of the 271 respondents 161 (59.4%) were women and 110 (40.6%) were men. The 50–60 year old age group had the highest number of respondents (98 out of 271 total respondents, or 36.2%). The highest number of respondents identified themselves as having practiced 20–25 years (47 out of 271, or 17.3%) One hundred twenty-seven respondents (46.9%) were physicians, of whom 34 (27%) specialized in palliative care.

Importance and definition of spiritual care

The survey used a 10-point scale, with 1 representing "not important at all" and 10 representing "very important". Of the 271 respondents, 182(67.2%) scored the role of spiritual care ≥7. Respondents age <40 years considered the role of spirituality more important than participants age 40–60 years and participants age >60 years (median 8, 7, and 6 respectively, *P*=0.006). Respondents' answers did not correlate with their individual specialties.

The mean score regarding the role of spiritual care among respondents who reported that they do not consider themselves spiritual (6.02) was statistically higher than that among respondents who do consider themselves spiritual (7.31; *P*<0.001). Years of practice and gender did not correlate with how respondents ranked the importance of spirituality.

Respondents' answers to the questions "What is your definition of spiritual care in your practice?" and "If you were to use spiritual practices, which ones would you choose to use?" are given in Table 2. The two most common definitions provided by respondents regarding the description of spiritual care were "alleviating spiritual/existential pain/suffering" (42.4%) and "offering emotional support as part of addressing psychosocial needs" (49.8%).

The five most common “spiritual practices” used were music therapy (42.4%), art therapy (29.5%), dignity therapy (27.7%), and yoga (26.9%), and healing touch (24.4%).

Ninety-seven respondents (35.8%), of whom 35 were physicians (36%), 52 were nurses (53%), and 29 were allied health professionals or dentists (30%), reported that they believe it is their role to explore the spiritual concerns of their cancer patients. 122 respondents (45%) reported that they believe it is “sometimes” their role to explore spiritual concerns, whereas 30 respondents (11%) reported that they do not think it is their role to do so.

Although all palliative care physicians and nurses accepted the role of providing spiritual care, only 15% of medical oncologists and 9% of oncology nurses did so. Age and gender did not correlate with whether one believed it was their role, whether if one referred patients for spiritual care assessment, whether one had spiritual training or education, or whether one felt they could adequately provide spiritual care. Years of practice did not correlate with whether one believed it was their role, or if they referred patients for spiritual care assessment. However, years of practice trended towards significance with having spiritual training in the past 2 years (P=0.05); those with 5–10 years of practice were most likely to have had training. Furthermore, whether respondents with 5–10 years of training felt they could adequately provide spiritual care trended toward significance (P=0.06). Of the respondents who reported that if they do not conduct spiritual assessment, they 23 (8.5%) always, 46 (17%) usually, 114 (42%) sometimes, 37 (14%) seldom, and 29 (11%) never refer patients for spiritual care; 22 of the respondents (8%) did not answer the prompt.

Of 271 respondents, 91 (33.6%) reported they seldom provide adequate spiritual care and 70 (25.8%) do not feel they can provide adequate spiritual care. Of the 271, respondents, 88 (33%) reported that they provide spiritual care most of the time. The majority of respondents who reported that they seldom provide adequate spiritual care or do not feel that they could adequately provide spiritual care were women (55.3%). Of the 161 respondents who reported that they either seldom provided or could not adequately provide spiritual care, 100 (62%) were age 40–60 years, 39 (24%) were age <40, and 22 (13%) were age >60 years; 64 of these respondents (40%) practiced in Europe, and 63 (39%) practiced in North America. The majority (75%) had been in practice >10 years.

Self-categorization, spiritual care training, and self-discovery

Eighty respondents (29.5%) claimed to have some kind of training or education regarding spiritual care. The proportion of women who received training or education (36.6%) was higher than that of men who received training or education (26.0%), but this difference was not significant. In fact, 169 respondents (62.4%) had not had any spiritual care training. In reply to the question “Which tools, training, or education are most necessary in order to offer spiritual care?”, 211 respondents (77.9%) cited attaining basic knowledge and skills in recognizing spiritual issues. The proportions of “spiritual” respondents who reported that attaining basic skills to recognize spiritual issues and consulting with trained chaplains were most necessary to offering spiritual care were significantly higher than those of “non-spiritual” respondents; P = 0.023 and 0.008, respectively.”

There was no significant difference between the proportions of “spiritual” and “nonspiritual” respondents who reported that they needed more training, needed to use referrals, or did not have enough time to fulfill the spiritual care needs of their patients. “Nonspiritual” respondents were significantly less likely than “spiritual” respondents to perform personal spiritual inquiry in the form of spiritual practice or contemplation (P≤0.001). The “spiritual” are pursuing their own spirituality by way of books (P=0.004), contemplation (P=0.03), and seminars in spirituality (P=0.049).

Personal spiritual inquiry

One hundred and seven respondents (39.5%) reported that they are not actively pursuing spiritual inquiry and 199 of the 249 respondents who answered this question (80%) reported that in the past two years, they had not pursued spiritual training to help provide spiritual care for cancer patients. Of the 50 respondents who pursued training to help patients, 38 (76%) read books and 29 (58%) attended seminars on spirituality.

Method of medical spiritual assessment

Most respondents (244; 90%) reported that they do not use a standardized questionnaire to assess their patients' spiritual needs. Of the 27 respondents who did report using such a questionnaire, 15 (56%) reported using the FICA; others reported using the SPIRIT, HOPE, SBI, and/or FACIT-Sp. Sixty-nine percent of the respondents reported performing spiritual assessments repeatedly throughout the illness trajectory, and 24% reported that they believe that spirituality should be assessed soon after diagnosis. In reply to the question "[What do] you feel keeps you and others from providing spiritual care?", 149 respondents (54.9%) reported that they believed they needed more training, 62 (22.9%) indicated the need to refer their patients to a specialist, 84 (31.0%) stated that they preferred referring their patients to chaplaincy, 111 (41.0%) reported that they did not have enough time, and 62 (22.9%) stated that they did not feel it was appropriate to do so (percentages exceed 100 because respondents could endorse more than one reason).

Participants who are "nonspiritual"

Two hundred six respondents (76.0%) considered themselves to be "spiritual" and 65 respondents (24.0%) considered themselves to be "not spiritual." Sixty eight percent of the respondents from Europe, 85% of the respondents from North America, 43% of the respondents from Australia, and 79% of the respondents from Asia considered themselves to be spiritual. The proportion of "spiritual" respondents who claimed a religious category (78%) was significantly higher than that of "nonspiritual" respondents (46%; $P \leq 0.001$). The respondents were relatively evenly split between men (45.9%) and women (54.1%), and the majority of respondents in this group (86.9%) were age 20–60 years. Considering oneself to be spiritual was significantly associated with claiming a religious category ($p<.001$). Interestingly, however, 55% of people who did not claim a religious category did consider themselves to be spiritual. By discipline, the least likely respondents to consider themselves to be not spiritual were palliative care doctors (10%) and dentists (13%)

Of the 71 respondents who did not claim a religious category, 45 (63.4%) reported that they seldom or could not provide adequate spiritual care. In addition, of the 61 respondents who reported that they were not spiritual, 50 (82%) claimed that they seldom or could not provide adequate spiritual care. ($P=0.001$)

One hundred ninety-two respondents (71%) claimed a religious affiliation. Of these respondents, (70%) claimed Christianity (Catholic or Protestant); other religious categories claimed included Buddhism, Hinduism, Islam, and Judaism. Age, years of practice, and gender was not associated with claiming a religious category.

Considering oneself "not spiritual" was correlated with answering "no" to the question "Do you think it is your role to explore the spiritual concerns of your cancer patients?" ($P \leq 0.001$), answering 'no' to the question, "Do you refer patients for spiritual care assessment?" ($P<0.034$), choosing none of the suggested tools for spiritual practice ($P=0.01$), and specifically not choosing healing touch as spiritual practice ($P=0.002$). The proportion of "nonspiritual" respondents who reported that they could not provide adequate spiritual care (82%) was significantly higher than that of "spiritual" respondents (59%;

P=0.001). The proportion of “spiritual” respondents who reported that they were pursuing spiritual inquiry was significantly higher than that of “nonspiritual” respondents (*P*≤0.001)”

Discussion

Our findings from this international survey indicate that a considerable number of oncology professionals, even when involved in a cancer organization designed solely to advance the science of supportive care are hesitant to include spiritual care as an aspect of one’s role as a caregiver. Before undertaking the present study, we believed that we would obtain ample information to prepare preliminary suggestions regarding an international approach to spiritual care. Instead, our survey results indicate that although MASCC members feel that spiritual care is important, few have the training or desire to address their patients’ spiritual care needs. Notably, respondents who did not view themselves as spiritual were less likely to perform this important aspect of oncologic care.

Studies have shown that spiritual discussions are a part of clinical care in less than 20% of visits and patients feel clinicians lack exploratory efforts in this area 30–50% of the time [14, 15]. Perhaps as Kafka suggested in 1919 “To write prescriptions is easy, but to come to an understanding with people is hard” [16]. However, patients want discussions of spirituality to influence the physician-patient relationship and 40–94% of patients are interested in having physician consider their spiritual needs [15]. Assessing patients’ spiritual needs can increase physicians’ awareness of their patients’ beliefs that potentially have clinical relevance, strengthen the doctor-patient relationship, and/or improve communication and satisfaction [17, 18].

Taking a spiritual history, even briefly, can identify patients who have spiritual distress or negative religious coping thoughts, including feelings of being punished or abandoned by God or feelings of fatalism [19], [20], [21]. These forms of negative religious coping have been associated with distress, confusion, depression, and decreased quality of life [6, 7]. One study found that most patients believe that having information about their spiritual beliefs might enhance their physicians' ability to encourage realistic hope (67%), give medical advice (66%), and individualize medical treatment (62%) [22]. Further, patients whose doctors spend a few minutes asking about their spirituality or what gives meaning to their lives, are more satisfied with their care [20], [23]. Patients' religious and spiritual beliefs can significantly affect their treatment choices, especially as those choices relate to having a living will, desiring cardiopulmonary resuscitation, or desiring life-sustaining measures in a near-death scenario [17, 18]. One study found that patients who reported that their religious/spiritual needs were inadequately supported by clinic staff were less likely to receive a week or more of hospice care (54% vs 72.8%; $P = 0.01$) and more likely to die in an intensive care unit (5.1% vs 1.0%, $P = 0.03$) than patients who reported that their spiritual/religious needs had been adequately supported. Among high “religious copers”, these differences resulted in higher end-of-life costs ($6533 vs $2276; $P = 0.005$) [24].

Embracing and exploring one’s spiritual side may be important in protecting care givers and physicians from burnout and compassion fatigue [25]. Additional training and guidance to help physicians introspect and self-reflect (similar to the meaning-based therapy [26] or dignity therapy [27] prescribed to patients) may be helpful on this quest. Other researchers have suggested that a “clinical intervention that would increase [an oncologist’s] level of spiritual awareness and his or her level of comfort associated with a personal perspective on death could help decrease the patients level of psychosocial distress” [28, 29]. The key may be that “Those who are more aware of their own spirituality will be better at recognizing, understanding and attending to their patients’ needs” [30]. As one oncologist stated, “Knowing what is important to our patients, what they treasure and think is worth fighting

for, and how they wish to be remembered helps guide the dialogue when we run out of treatment options" [31]. If physicians don't use spiritual, existential inquiry when asking patients about their history, it is improbable that they could expect to know their most deeply held beliefs.

Our study was not without potential limitations. One concern with using this type of survey is the selection bias of our respondents, either selecting for those most interested in a positive or negative sense. Selection bias and language barriers can confound responses to questions of an emotional nature and thus affect responses and response rate. Lastly, because ours was an international language survey, we suspect that some respondents assumed "spiritual" to mean "religious" and answered accordingly.

We developed this survey to better understand the practice and meaning of spiritual care for MASCC members. Ultimately we hoped to provide a rationale for the need to develop culturally sensitive recommendations to provide guidance to supportive care professionals on how to start approaching spiritual care as part of their practice. The results of our survey study indicate that although MASCC members feel that spiritual care is important, few have the training (or possibly desire) to assess and attend to their patients' spiritual needs. Surprisingly, we learned that more time and effort is needed to identify the optimal method of training MASCC members to understand how to triage spiritual crises and provide spiritual care. Additional effort must be invested to help MASCC members recognize the importance of their role in providing spiritual care and overcome barriers to assessing spiritual needs and providing spiritual care before guidelines for international spiritual care approaches can be developed.

Acknowledgments

This research was supported in part by the National Institutes of Health through M. D. Anderson's Cancer Center Support Grant CA016672.

References

1. Puchalski C, Ferrell B, Virani R, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. J Palliat Med. 2009; 12:885–904. [PubMed: 19807235]
2. Chochinov HM, Cann BJ. Interventions to enhance the spiritual aspects of dying. J Palliat Med. 2005; 8(Suppl 1):S103–S115. [PubMed: 16499458]
3. Vallurupalli M, Lauderdale K, Balboni MJ, et al. The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. J Support Oncol. 2012; 10:81–87. [PubMed: 22088828]
4. Puchalski CM, Dorff RE, Hendi IY. Spirituality, religion, and healing in palliative care. Clin Geriatr Med. 2004; 20:689–714. vi-vii. [PubMed: 15541620]
5. Pearce MJ, Coan AD, Herndon JE 2nd, et al. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. Support Care Cancer. 2012; 20:2269–2276. [PubMed: 22124529]
6. Hills JPJ, Cameron JR, Shott S. Spirituality and distress in palliative care consultation. Journal of Palliative Medicine. 2005; 8:782–788. [PubMed: 16128652]
7. Boscaglia N, Clarke DM, Jobling TW, Quinn MA. The contribution of spirituality and spiritual coping to anxiety and depression in women with a recent diagnosis of gynecological cancer. Int J Gynecol Cancer. 2005; 15:755–761. [PubMed: 16174220]
8. Ramondetta L, Brown A, Richardson G, et al. Religious and Spiritual Beliefs of Gynecologic Oncologists May Influence Medical Decision Making. Int J Gynecol Cancer. 2011; 21:573–581. [PubMed: 21436706]

9. Balboni TA, Paulk ME, Balboni MJ, et al. Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. J Clin Oncol. 2010; 28:445–452. [PubMed: 20008625]
10. Cocconi G, Caminiti C, Zaninetta G, et al. National survey of medical choices in caring for terminally ill patients in Italy, a cross-sectional study. Tumori. 2010; 96:122–130. [PubMed: 20437869]
11. Seal C. The role of doctors' religious faith and ethnicity in taking ethically controversial decisions during end-of-life care. J Med Ethics. 2010 jme.2010.036194 [pii] 10.1136/jme.2010.036194.
12. Surbone, A.; Konishi, T.; Baider, L. Spirituality in cancer care. In: Olver, I., editor. Cancer Supportive Care and Survivorship. Edition. Springer Verlag; 2011. p. 419-425.
13. Survey Monkey Website: www.SurveyMonkey.com. In Edition. 2010.
14. Moadel A, Morgan C, Fatone A, et al. Seeking meaning and hope: self-reported spiritual and existential needs among an ethnically-diverse cancer patient population. Psychooncology. 1999; 8:378–385. [PubMed: 10559797]
15. Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: professional boundaries, competency, and ethics. Ann Intern Med. 2000; 132:578–583. [PubMed: 10744595]
16. Kafka F. A Country Doctor. 1919
17. Balboni TA, Vanderwerker LC, Block SD, et al. Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol. 2007; 25:555–560. [PubMed: 17290065]
18. Vincent JL. Forgoing life support in western European intensive care units: the results of an ethical questionnaire. Crit Care Med. 1999; 27:1626–1633. [PubMed: 10470775]
19. Thune-Boyle IC, Stygall J, Keshtgar MR, et al. Religious/spiritual coping resources and their relationship with adjustment in patients newly diagnosed with breast cancer in the U.K. Psycho-Oncology. 2012 Published online (willeyonlinelibrary.com).
20. Kristeller JL, Sheets V, Johnson T, Frank B. Understanding religious and spiritual influences on adjustment to cancer: individual patterns and differences. J Behav Med. 2011; 34:550–561. [PubMed: 21442244]
21. Pargament KI, Zinnbauer BJ, Scott AB, et al. Red flags and religious coping: identifying some religious warning signs among people in crisis. J Clin Psychol. 1998; 54:77–89. [PubMed: 9476711]
22. Lederberg MS, Fitchett G. Can you measure a sunbeam with a ruler? Psychooncology. 1999; 8:375–377. [PubMed: 10559796]
23. Astrow AB, Wexler A, Texeira K, et al. Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? J Clin Oncol. 2007; 25:5753–5757. [PubMed: 18089871]
24. Balboni T, Balboni M, Paulk ME, et al. Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer. 2011; 117:5383–5391. [PubMed: 21563177]
25. Kearney MKWR, Vachon ML, et al. Self-care of Physicians Caring for Patients at the End of Life:"Being Connected… A Key to my Survival". JAMA. 2009; 301:1155–1164. [PubMed: 19293416]
26. Breitbart W, Rosenfeld B, Gibson C, et al. Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial. Psychooncology. 2010; 19:21–28. [PubMed: 19274623]
27. Chochinov HM, Hack T, Hassard T, et al. Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. J Clin Oncol. 2005; 23:5520–5525. [PubMed: 16110012]
28. Gioiella ME, Berkman B, Robinson M. Spirituality and quality of life in gynecologic oncology patients. Cancer Pract. 1998; 6:333–338. [PubMed: 9824424]
29. Seccareccia D, Brown JB. Impact of spirituality on palliative care physicians: personally and professionally. J Palliat Med. 2009; 12:805–809. [PubMed: 19624268]
30. Surbone A, Baider L. The spiritual dimension of cancer care. Crit Rev Oncol Hematol. 2010; 73:228–235. [PubMed: 19406661]
31. Schapira L. Communication at the end of life. J Oncol Pract. 2008; 4:54. [PubMed: 20856778]

The Survey

1. What is your definition of spiritual care in your practice? Check two
2. What is the role of spiritual care in the total care of the cancer patient?
3. If you were to use therapies, which therapies would you consider using?

   Dignity therapy; Yoga; Art therapy; Music; Logo therapy, Healing touch, Other
4. Is it your role to explore the spiritual concerns of your cancer patients?
5. If you do not conduct a spiritual assessment, do you refer patients?
6. When you refer patients, whom do you refer them to for the assessment?
7. At which stage(s) it is most appropriate for a spiritual assessment to be done?
8. Do you use a standardized spiritual questionnaire / is one used in your practice?
9. At this point in your life, are you pursuing any active personal spiritual inquiry?
10. In past 2 years have you pursued any spiritual care training?
11. In your opinion, can you adequately provide spiritual care?
12. Check all that you feel keeps you and others from providing spiritual care?
13. Have you ever had any kind of training or education regarding spiritual care?
14. Which tools, training, or education are most necessary in order to offer spiritual care?
15. Do you claim a religious category for yourself?
16. Do you consider yourself a spiritual person?

Table1

Demographic characteristics of respondents (N=271)

Characteristic	Number (%)
Sex	
Women	161 (59.4)
Men	110 (40.6)
Age, years	
20–30	12 (4.4)
30–40	52 (19.2)
40–50	73 (26.9)
50–60	98 (36.2)
≥60	36 (13.3)
Practice experience, years	
1–5	33 (12.2)
5–10	37 (13.7)
10–15	42 (15.5)
15–20	36 (13.3)
20–25	47 (17.3)
25–30	37 (13.7)
>30	39 (14.4)
Region of practice [1]	
North America	115 (42.4)
Europe	96 (35.4)
Asia	29 (10.7)
Australia	17 (6.3)
Africa	6 (2.2)
Middle East	5 (1.8)
South America	2 (0.7)
Profession	
Physician	127 (46.9)
Nurse	72 (26.2)
Allied Health	47 (17.3)
Dentist	26 (9.6)

[1] Not specified for 1 respondent

Table2

Responses to selected questions

Questions	No. of patients (%)
What is your definition of spiritual care in your practice?(Please select 2 categories.)	
Alleviate spiritual/existential pain/suffering	115 (42.4)
Offering emotional support as part of addressing psychosocial needs	135 (49.8)
Helping patients' illness narrative and life review	28 (10.3)
Helping patients examine and reconstruct their spiritual beliefs answering specific spiritual concerns	48 (17.7)
Offering spiritual practices such as prayer	23 (8.5)
Helping patients find meaning in life through various therapies	0 (0%)
If you were to use spiritual practices, which ones would you choose to use? (Please check all that apply.)	
Music therapy	115 (42.4)
Art therapy	80 (29.5)
Dignity therapy	75 (27.7)
Yoga therapy	73 (26.9)
Healing touch	66 (24.4)
Other	42 (15.5)
None	36 (13.3)
Logo therapy	23 (8.5)

Table3

Disciplines of respondentswho indicated they either seldom provided spiritual care or did not feel they could adequately provide spiritual care

Discipline	Number (%)
Physician (non-palliative care)	62 (38.5)
Nurse	35 (21.7)
Allied health	29 (18)
Palliative care physician	13 (8.1)
Dentist	22 (13.7)