SPIRITUAL CARE OF THE HOSPITALIZED PATIENTS FOLLOWING ADMISSION TO THE CARDIAC CARE UNITS: POLICY IMPLICATIONS

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SPIRITUAL CARE OF THE HOSPITALIZED PATIENTS FOLLOWING ADMISSION TO THE CARDIAC CARE UNITS: POLICY IMPLICATIONS

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ABSTRACT

Heart disease is the major cause of death among Palestinians. Significantly higher levels of stress can lead to repeated hospitalizations; consequently, preventing and relieving stress becomes a major concern for this group of patients in many countries. One of the approaches to reduce stress is the provision of spiritual care, which helps to decrease levels of stress and increase patients’ abilities to cope emotionally.

Although it is important, health care professionals tend to ignore spiritual care and focus on meeting the physical needs of their patient. Recently, more attention has been paid to spirituality in health care and the relationship between spirituality and illness is at the center of a growing body of literature. As a result, many hospitals in the Western countries have started to offer spiritual care to their clients. In Gaza Strip, there is no clear policy about providing spiritual care. The present study aimed to assess if spiritual care is provided to hospitalized cardiac patients who live in Gaza Strip, who should provide this care, explore the barriers to provision of such care, and how to overcome these barriers.

The design for the study used both qualitative and quantitative approaches in data collection. A total of 279 cardiac patients (response rate of 99.29%) and twelve healthcare providers participated in the study. A quantitative data collection approach was used to collect data from cardiac patients, while a qualitative approach using a semi-structured interview was used to collect data from healthcare providers.
Results revealed that there is a severe shortage of spiritual care provision to cardiac patients. The majority (n=159, 57%) preferred that nurses provide such spiritual care to them.

The responses of healthcare providers regarding the barriers and obstacles they face in providing spiritual care were grouped into several categories. These barriers included inadequate education and training, ambiguity about spirituality, inadequate time, shortage of staff, policy-related barriers, and individual-related barrier. Most of the barriers reported by the health care participants have been reported in the literature.

To overcome these barriers, health care professionals suggested several strategies that were categorized under the following themes: policy change, organizational interventions, including spirituality in health education and other miscellaneous interventions.

Because heart disease is the leading cause of death in Palestine and providing spiritual care to cardiac patients will help to decrease their stress and length of stay in the hospital, while also decreasing the cost of their treatment, health policy-makers need to pay more attention to this groups of patients and should adopt a spiritual care policy as an operative component of the health care system.
DEDICATION

To the soul of my father, who passed away while waiting for the day I would complete this study and doctoral degree. To the soul of my mother-in-law; who passed away while she too was looking forward for this moment. To my mother, who accompanies me with her prayers and encouragement all the time. To my friend…my soul twin…my husband, who was the energetic motor and the motivating soul. I believe if God had not sent him to my side, finishing this work might have become impossible. To all of them, I dedicate this study.

I also dedicate this dissertation to my moons in the dark sky, my children Salaheddin, Yaqeen, Misk, and Omar. You suffered a lot while I was busy most of the times with my work.

To my brothers, sisters, friends, and colleagues…..

To all cardiac patients, who are deprived of their right of spiritual care…..

To my directing supervisor and all of the committee members…..

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CHAPTER I
INTRODUCTION

Heart disease was the leading cause of death among Palestinians in Gaza Strip (Palestinian Health Information Center, 2010 & Ministry of Health-Gaza: Health Information Center, 2011, Ministry of Health, PHIC, 2011). In 2010, deaths related to heart disease accounted for 23.5% of total deaths (figure 1-1), while cancer ranked second accounting for 11.8% of all deaths reported in 2010 in (Ministry of Health-Gaza: Health Information Center, 2011).

Figure 1-1: Leading Causes of Death in Gaza Strip. Source; Ministry of Health-Gaza: Health Information Center, 2011, Ministry of Health, PHIC, 2011)
Cardiac patients are more liable to risk and delayed recovery from heart attacks when they experience stress, hostility, anger, depression, and social isolation (Harvard Men’s Health Watch, 2006). As a consequence, they are more subject to repeated hospitalization. Rieck (2000) argued that hospitalized patients are exposed to higher levels 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. Therefore, prevention and relief of suffering and alleviating stress become a major concern at the end stage of heart failure (Oates, 2004). While cardiac diseases are associated with depression and stress, the number of patients diagnosed with heart disease is growing (HF Commission, 2008). Congruently, depressive disorders have become the fourth leading causes of illness and disability among adults worldwide (Duckworth, 2002 as cited by Irfan, 2002). Such increases in the number of stressors and cardiac problems may suggest the necessity to introduce new trends in treatment, such as provision of spiritual care, in conjunction with traditional clinical medicine. Therefore, this study aims to assess if spiritual care is provided to hospitalized cardiac patients who live in Gaza Strip, the barriers for providing such care, and how these barriers can be overcome, and to explore who should provide spiritual care to this group of patients.

Healthcare 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 a day for cardiac patients can convey acceptance, understanding, and caring about their patients and their problems,
while showing respect and acceptance of their personal decision-making capabilities (Barry, 1996).

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 healthcare providers to include physical, psychological, socio-cultural, and spiritual dimensions in their interventions (Timby, 2009). The World Health Organization (WHO) definition of health clearly included a spiritual aspect of health (WHO, 1998). In spite of such assertions regarding the importance of including emotional and spiritual needs in patient care, there is evidence in the literature that healthcare providers emphasize meeting the physical, social, and psychological needs of their patients, and that they seldom recognize the concomitant spiritual needs of the patient (Piles, 1990; Kuuppelomäki, 2001; Stranahan, 2001; Taylor & Mamier, 2005; Musa, 2007; McSherry and Jamieson, 2010). As a consequence, meeting patients’ spiritual needs is often neglected (Forbes, 1994; Camp 1996; Kuuppelomäki, 2001; Stranahan, 2001; Taylor & Mamier, 2005; Musa, 2007; McSherry and Jamieson, 2010).

Recently more attention has been paid to spiritual care. Over the past 25 years, more and more researchers, health care professionals and educators have turned their attention to this aspect of care (Murray, Kendall, Boyd, Worth, and Benton, 2004). The relationship between spirituality and illness is at the center of a growing body of literature (Kaye & Raghavan, 2002). As a result, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recognized that patients’ “psychosocial, spiritual and cultural values affect how they respond to their care” (Joint Commission Resources, 2003, p. RI-8) and has concentrated on spirituality and emotional well-being as essential
aspects of patient care. In practice, ignoring patients’ spiritual needs means inability to acknowledge the totality and the holistic view of the human being (Gray, Steele, Sweeney, and Evans, 1994). Few decades ago, Carson (1989) argued that holistic care cannot 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 (McSherry, 1983). Thus, neglect or inadequate provision of spiritual care makes the claim of providing holistic care by healthcare providers questionable.

It is well-known that psychological distress and poor psychological well-being may result in increased use of both inpatient and outpatient medical services (Manning & Wells, 1992). In 2003, the cost of referring patients for cardiac catheterization, which was unavailable in Gaza Strip, was 0.9 Million New Israeli Shekels (NIS) out of a total cost of 13,730,743 NIS for referring patients for treatment outside Gaza Strip (Abed, 2007). Such a high cost is a heavy burden for the budget of the Ministry of Health. Therefore, it is argued that giving attention to meet the spiritual needs of clients in general, and cardiac patients in particular, will minimize the use of both inpatient and outpatient medical services. That in turn will be reflected in reducing the total cost of the services provided to these patients. Therefore, economic analysis of the health care system, one of the most expensive sectors, may require taking more practical steps and establishing new policies that mandate spiritual care as an essential criterion of high-quality and effective health services.
Offering Spiritual Care within the Health Care System

Even when spiritual care is considered an important aspect of health care, there is no widespread agreement about who should and would be able to offer spiritual care within the health care system (Reed, 1991; Highfield, 1992; Camp, 1996; Ross, 1998; Taylor, 2002; Handzo, & Koenig, 2004; Pronk, 2005; Sawatzky & Pesut, 2005; Taylor, 2005; Baldacchino, 2006; Musa, 2007). Although several hospitals in Western countries assigned chaplains and pastoral teams to address the emotional and spiritual needs of the patients, nurses, physicians, clinicians, and other health caregivers can play equally important roles (Clark, Drain, & Malone, 2003). Thus, health workers need some academic preparation to enable them to offer spiritual care. The awareness of spirituality among medical educators has expanded notably over the past two decades. Since 1992, the number of medical schools teaching spirituality courses has increased significantly (Puchalski, 2002). The Association of American Medical Colleges (AAMC) called for the establishment of learning objectives and methodology for teaching courses on spirituality, cultural issues, and end-of-life care (Puchalski, 2002). Unfortunately, this attitude is absent in Gaza, since the curricula of schools teaching several health professions do not include issues related to spirituality (Abdul-Aziz, 2006). The American Institute of Medicine lists spiritual well-being as one of six domains of quality supportive care of the dying (Field & Cassel, 1997), which could apply to other patients such as those diagnosed with heart disease. Therefore, some investigators have suggested that physicians should have a routine inquiry about the relevance of spirituality to the patient within the context of taking a medical history (Post, Puchalski, & Larson, 2000).
According to Ministry of Health-Gaza: Health Information Center report on manpower in the Ministry of Health in the year of 2010, the number of registered nurses in Gaza Strip was 2,194 (27.5% of total personnel) compared to 1,632 physicians (20.3% of total human resources) (Ministry of Health-Gaza: Health Information Center, 2011A). Therefore, nurses and doctors comprise the backbone of the health care systems. Since nurses have the advantage that they spend more time with patients and they are more accessible than other healthcare providers, hospitalized patients may seek help from them (Highfield, 1992). Furthermore, the nurses’ proximity to their patients puts them in a unique position for fulfilling the spiritual needs of their patients. Ross (1994) claims that intervention to resolve spiritual needs appear to have a positive effect on patients’ health and their quality of life.

“There is a general assumption that nurses have the skills, knowledge and expertise to undertake a spiritual assessment” (McSherry & Ross, 2002, p.479). Highfield & Cason (1983) argued that merely the actual presence of nurses can be considered as a kind of spiritual care. The suitability and efficiency of this care depend on the individual nurse’s action (or lack of action) responding to patient needs. Furthermore, the American Association of Colleges of Nursing (1986, p. 5) recommends that nursing education should ensure the nurse’s ability to “comprehend the meaning of human spirituality in order to recognize the relationships of beliefs to culture, behavior, health, and healing,” and to plan and implement this care. Nursing education in Gaza Strip does not reflect any interest in including attention to aspects of spirituality in the nursing curricula. For example, spirituality is dealt with solely in a one-credit-hour course in only one school of
nursing out of the six nursing programs in Gaza Strip that offer Bachelor and Associate degrees in nursing (Abdul-Aziz, 2006).

Any inadequacy in the nursing practice in providing spiritual assessment and care may question the accuracy of their practices (Oldnall, 1996; Highfield & Cason, 1983). If spiritual care is neglected as a vital component of nursing care, other healthcare providers are required to provide it (Strang & Strang, 2002). Congruently, Derrickson (1996) believes that each member of the hospital team should be able to recognize spiritual work and its dimensions in care and to listen respectfully to patients’ individual expressions of their spirituality. It may be argued that every member of the health care team either working in inpatient or outpatient facilities, in acute or chronic settings, or in public or private health care facilities, needs to be competent in satisfying the patients’ spiritual needs.

Similarly, Greenberg (2003, p. 3) added that “Physicians are becoming much more attuned to helping patients to access spirituality as a resource in both individual and traditionally communal ways” and many authors and scientists have called for replacing the biopsychosocial model for health care with a biopsychosocial-spiritual model. According to the biopsychosocial-spiritual model, a holistic approach of taking care of the physical, mental, and spiritual components of health should be considered when dealing with patients (Anandarajah, 2008). The philosophy of holism was reflected in WHO’s new definitions of health which was modified to state: “health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity” (WHO, 1998, p.1). At the same time, the Association of American Medical Colleges (AAMC), the American College of Physicians, and the Joint
Commission on Accreditation of Healthcare Organizations (JCAHO) recommended including spirituality in the medical teaching curricula (Loboprabhu & Lomax, 2010).

The Concept of Spirituality

“The word 'spirit,' in Greek culture, is contrasting to body and material reality. In modern Western cultures, a spiritual person who’s the one impartial in material gain or worldly concerns. In Hebrew, spirit is opposed to death, destruction and negative aspects of the law, such as imposition, fear and punishment. Spirit is understood to be within the body, providing the life force, acting through it, and motivating action” (Golberg, 1998, p. 837). Reviewing the literature regarding spirituality makes it very clear that the definition of spirituality is one of the most complicated issues. Although there is widespread agreement about the importance of considering spirituality in health care (Chaturvedi, 2007; McSherry & Ross, 2002; Mako, Galek, Poppito, 2006; O’Connor, Guilfoyle, Breen, Mukhardt, & Fisher, 2007; Larson, Larson, & Koenig, 2002; Levin, Chatters, & Taylor, 2005), the term is still ambiguous and lacks a clear definition and understanding (McSherry & Ross, 2002).

In addition, there is some kind of non-distinction between spirituality and the emotional and psychological aspects from the other side (Halm, Myers, & Bennetts, 2000). At the same time, debates exist whether spirituality differs from religion (Harrison, 1993; Kearney& Mount, 2000; Rumbold, 2003; McGrath, 2004; Speck, Higginson & Addington-Hall, 2004) or does not (Chaturvedi, 2007). Most researchers who believe that there is a difference between spirituality and religion also believe that
spirituality is broader than religion (Harrison, 1993, Oldnall, 1996). Spirituality can be perceived as a process of meaning-making (McGrath, 2004), while religion is different. The person may be spiritual (seeking self-awareness, self-empowerment and self-actualization) but without affiliation to any religious group (Speck, Higginson & Addington-Hall, 2004). Spirituality may include hope (Miller, 1985), happiness, crying, suffering (Limdholm & Eriksson, 1993), laughing, dancing, using colors, relationships with other people (Mayeroff, 1971), hugging and holding, and any other aspect which is meaning-making for the individual (Peterson 1985). Furthermore, Cohen (1996) added appreciation to food, sex, wine, music, and dancing.

Some authors defined spirituality needs as “any need related to a person’s belief, practices, habits, norms, customs, and rituals” (Halm, Meyer, and Bennett, 2000, p. 54). From a different aspect, spiritual pain can be defined as “pain caused by extinction of the being and meaning of the self” (Tamura, Ichihara, Maetaki, Takayama, Tanisawa & Ikenaga, 2006). It is clearly recognized that there is an embedded difficulty in the West with the synergy of spirituality and religious beliefs (Rasool, 2000). According to Fahlberg & Fahlberg (1991), the difficulty of defining spirituality is related to its association with religion and the cultural emphasis on the material realm.

Spirituality and Health Care

At the clinical level, several studies have emphasized that spirituality is associated with decreased anxiety and depression (Mickley & Soeken, 1993; Thoresen & Harris 2002). Similarly, Tuck, McCain, & Elswick, (2001) showed that practicing spirituality
by AIDS patients has been associated with decreased psychological distress and depression and increased capabilities in emotional coping. However; Clark, Drain, & Malone (2003) claimed that spiritual distress has its own destructive effect on physical well-being.

The role of spirituality in coping with chronic illnesses is gaining interest within health care domains. Several research studies have shown an increased interest in the holistic view of health care, and consequently in the emotional and spiritual needs as inextricable from physical and psychological needs (Miller & Thoreson, 1999; Mueller, Plevak, & Rummans, 2001). “Spiritual care is important for all people, not only those who express a religious belief, as spirituality is a fundamental need that goes beyond religious affiliation” (Rasool, 2000, p. 1481). Especially for patients with chronic or incurable diseases, spiritual care is of very high priority. Spiritual care is an essential component of palliative care and plays an integral role in the care of the terminally ill (Hills, Paice, Cameron, & Shott, 2005; Puchalski, 2002). For cardiac patients, the patients’ physical capabilities diminish and the lifespan is reduced. Palliative treatment should be able to address the spiritual needs, as an integral part of holistic care (Oates, 2004).

In spite of the agreement about the generally positive relationship between spirituality or religion and health (Chaturvedi, 2007; Levin, Chatters, & Taylor, 2005), the literature reveals the presence of certain contradictions, such as the refusal of blood transfusion by Jehovah’s Witnesses and the refusal of vaccinations by adult Christian Scientists and members of the Orthodox Reformed Church (Pembroke, 2008). Another example is Negative Religious Coping (NRC) (Koenig, Pargament, & Nielsen, 1998).
According to Pembroke (2008), persons may experience NRC if they are involved in one or more of specific conditions such as perceiving the illness as a punishment, “questioning God’s love, reappraising God’s power, or holding of resentment against God” (p.551). Going through NRC makes patients more susceptible to depression and anxiety (Pembroke, 2008).

Reviewing the literature of spiritual care in the health care system shows that “America is leading the way in exploring the concept of spirituality and establishing its importance in holistic care,” while health caregivers in Britain began somewhat later to devote more attention to this issue (Oldnall, 1996, p.23). At this time, several hospitals in Western countries offer spiritual care by chaplains, at least when so requested (Clark, Drain, and Malone, 2003). However, in Gaza Strip, such services are not available. Almost no formal spiritual care is provided at the hospitals or other health care facilities. Therefore, this study aims to assess whether any spiritual care is provided to hospitalized cardiac patients who live in Gaza Strip the barriers to provision of such care and how these barriers can be eliminated.

Effect of Unmet Spiritual Needs on Cardiac Patients

Mytok & Knight (1999) believe that spiritual-beliefs work as a protector against stressful physical and emotional events associated with chronic illnesses, including heart failure and other cardiac diseases. Patients with heart disease are subject to risk and delayed recovery from heart attacks when they experience stress, hostility, anger, depression, and social isolation (Harvard Men’s Health Watch, 2006). Therefore, they are
more likely to experience repeated hospitalization. Rieck (2000) argued that hospitalized patients are exposed to higher levels 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 caregivers, uncertainty, and invasion of privacy. Therefore, prevention and relief of suffering and alleviating stress become a major concern at the final stage of heart failure (Oates, 2004). At the clinical level, several studies have emphasized that spirituality is associated with decreased anxiety and depression (Mickley & Soeken, 1993; Thoresen & Harris 2002).

Studying the effect of emotional distress on coronary heart disease, Denollet (1997) reported that depression, stress, anger, and negative emotions in general were strongly associated with increased cardiac death and re-infarction, independently of disease severity. On the other hand, Pratt et al. (1996) confirmed that depression increased the risk of myocardial infarction (MI) and Anda et al. (1993) found that depression and feelings of hopelessness were associated with increased mortality from ischemic heart disease (as cited in Clark, Drain, & Malone, 2003). Furthermore, emotional comfort of spirituality was found to have a positive effect on a patient’s physical health (Kiecolt-glaser, Garner, Speicher, Penn, Holliday and Glaser, 1984 as cited by Clark, Drain, & Malone, 2003).
The Islamic religion, as most of other religions, takes care of the physical and spiritual components of the individual. In Islam, the human being is a “united body and spirit” (Isgandarova, 2005, p.86). Although the soul has its own maladies (forgetting the presence of the Divine, selfishness, and so on) and the body has its own complaints, both of them are combined in one entity (Isgandarova, 2005, p.87). According to Rasool (2000), “Islamic teachings and practice have enabled the production of a holistic framework in meeting the physical, spiritual, psycho-social and environmental needs of individuals and communities” (p. 1476). There is no chance for differentiating spirituality from religion. “The concept of religion is embedded in the umbrella of spirituality” (Rasool, 2000, p. 1479). Spiritually is inseparable from the religion, which offers the way of salvation and life (Isgandarova, 2005). Based on the Quran and guidance of the Prophet Mohammed (Peace Be Upon Him), spirituality in Islam is built upon the “unity” or “Tawheed,” which means believing that there is no God except Allah. Muslims recognize the Divine, and they inquire about “meaning, purpose and happiness” in both their lives (worldly life and the one after death) (Rasool, 2000, p. 1479; Isgandarova, 2005). This is one of the differences between the Western cultures and the Islamic view of spirituality. Besides that, wine, which was defined as an aspect of spirituality by Cohen (1996), is not permitted in Islam.

In this study, spirituality will be defined and measured within the boundaries of Islamic religion. According to Rahman (1980), the spiritual discipline “which educates and trains the inner self of man is the core of the Islamic system. It also frees man from
the slavery of the ‘self’, purges his soul from the lust of materialistic life and instills in humans a passion of love for Allah. It is through the process of patience, perseverance, and gratitude that opens the door for spiritual and physical well-being” (p. 253).

As Islam takes care of the soul and the body (Isgandarova, 2005), it gives the health of individuals considerable importance and attention. Isgandarove argued that spirituality in Islam implies a healthy relationship between the body and the spirit (p. 85). Although the Quran is not a medical book, it gives guidelines for health and treatment. According to El-Kadi (1993), the Holy Quran has a clear, positive influence on health either through healing from illnesses or health promotion. The healthy effect of the Quran is achieved through three approaches; the legal approach, the guiding approach, and the direct healing approach (El-Kadi 1993). As Muslims strive to obey Allah, they adhere to his guidance in life, including those related to health issues. Prophet Mohammed (PBUH) taught Muslims that “your body has rights over you,” which means that the Muslim is responsible to protect his/her body through maintaining his/her health. Also he said “Ask Allah for forgiveness and wellbeing.” Medicine, prayers, fasting, and “ruqya” (healing with prayer) are all considered methods for remedy in Islam. Although Muslims can seek treatment from illnesses through medical means, they believe that physicians are just tools, and the ultimate result is only made by Allah. Such a belief allows Muslims to live in genuine spiritual peace (Athar, 2008).

General health promotions are offered by Islam, through both the Quran and Sunnah (following the words and actions of Prophet Mohammed). Taking care for proper hygiene and diet, avoiding accidents such as fire and poisoning, and even isolating people with infectious diseases are all emphasized in Islam.
Healthy diet relates to the interconnectedness of physical and spiritual health as “healthy eating not only satisfies hunger but also has an effect on how well we worship” (Stacy, 2008a, para.7). “O ye people! Eat of what is lawful and good on earth, and do not follow the footsteps of Satan. Verily he is to you an avowed enemy.” (Holy Quran 2:168).

Perception of Muslims Regarding Health and Illness

Muslim patients consider an illness as atonement, rather than punishment, for their sins, and death as part of a journey to meet their God (Athar, 1993 & 1998). Illnesses can attack both people who are considered highly religious and adhere to God’s orders as well as those who do not believe in God at all. Experiencing disease is a normal part of the natural life. “And certainly, We shall test you with something of fear, hunger, loss of wealth, lives and fruits, but give glad tidings to the patient ones” (Holy Quran, 2:155). For this reason, Muslims who recognize this well cannot embark on questioning God’s love, why this happens, or the purpose of life. Muslims believe that they were created just to worship God.

The perception of Muslim patients about health and illness begins with the notion of accepting illness and death with patience, meditation, and prayers. Muslims understand illness, suffering, and dying as a natural part of life and a test from Allah (Rasool, 2000; Asadi-Lari, Madjd, & Goushegir, 2008). According to Al-Jibaly (1998), an un-well Muslim should keep in mind that his or her sickness is a check coming from Allah; it brings tidings of forgiveness and mercy to the person afflicted. Thus, avoiding complaint
about such suffering, accepting it with patience and satisfaction, and asking Allah to reduce this distress are highly encouraged. Muslims always should obey God and thank Him for everything that happens to them, whether perceived as a bad or a good experience. “The reality is that God is just, therefore, whatever situation a believer finds himself in, he knows there is goodness and wisdom embedded in it” (Stacy, 2008, para. 7). Consequently, seeking treatment for illness is not considered as a sign of conflict with confidence in Allah for a cure. Prophet Muhammad said (in the meaning of): "Seek treatment, because Allah did not create a sickness but has created a treatment for it except for old age" (Rasool, 2000). Therefore, Muslims basically are protected against NRC.

Terminally ill patients, including patients with end-stage heart failure, experience fear of death and loneliness, which may end with a spiritual crisis (Asadi-Lari, Madjd, & Goushegir, 2008, p.74). Approaching death may stimulate several questions regarding the presence of God, the power of God, love by God, the purpose of life, and why this is happening (Pembroke, 2008). Anxiety, depression, despair, and hopelessness may be the result (Asadi-Lari, Madjd, & Goushegir, 2008, p.74). It may be argued that Muslim cardiac patients, if they receive proper and adequate spiritual care, will be able to overcome such a crisis or even avoid having to endure it. Reminding Muslim cardiac patients about the purpose of life (God worship), value of patience, nature of death as a passage between the two segments of a continuous life (Asadi-Lari, Madjd, & Goushegir, 2008), and that this disease is a chance for forgiveness; all of these can minimize the stressors which they face.
Problem Statement

In Palestine, heart disease is the leading cause of death (Palestinian Health Information Center, 2010 & Ministry of Health-Gaza: Health Information Center, 2011). The incidence of heart disease is usually associated with stress (Timby, 2009). Besides the day-to-day stress facing most individuals, Palestinians who live in Gaza Strip experience a higher level of stress because of the continuous Palestinian-Israeli conflict, the ongoing blockade, the prevailing political chaos between Fateh and Hamas, and repeated wars and violence in the area. Such a high level of stress will predispose cardiac patients living in Gaza to more cardiac complications and worsen their prognoses. Therefore, providing spiritual care to this group of patients may help to reduce their stress level and decrease stress-related complications.

A large body of literature about offering spiritual care for cardiac patients now exists, but was developed in Western countries. Several authors questioned whether spirituality is associated with religion or not. For example, Kaye & Robinson (1994) and Wykle & Segal (1991) argued that religion, an expression of a person’s spiritual perspective, is a primary means of coping with stress of illness and disability. According to Lunn (2003), spirituality is important in developing countries and traditional societies, such as Gaza Strip, where medical and comfort resources are limited. Islamic religion, which is embraced by the great majority of people living in Gaza Strip, could have an important role in relieving stress experienced by cardiac patients who live in Gaza Strip.

Although there are several studies on spiritual care in health care in general and for cardiac patients in particular, there is but scanty literature about spiritual care for
cardiac patients in developing countries, including Muslim countries. Furthermore, there are no studies that were conducted in Gaza Strip to investigate whether spiritual care is actually offered to cardiac patients or to investigate the barriers to offering spiritual care for cardiac patients in Gaza Strip.

Study Purpose

Almost all the reviewed studies, with a few exceptions, came from a context within a Western spiritual view of point. Although spirituality in Islam has several similarities with aspects reported in literature, in most relevant aspects it differs in some specific points. For example, while some of the literature in Western countries relates spirituality to religion and others do not connect it to any religion (Speck, Higginson, & Addington-Hall, 2004), in Islam, spirituality is very closely connected with religion, since it is based on 'unity' (belief in one God) (Rasool, 2000). It is essential for Muslim researchers conducting studies related to spirituality in Muslim societies to take these differences about spirituality into consideration. In Gaza Strip, where most inhabitants (99.83%) are Muslims (PCBS, 1997), no studies were conducted related to spiritual care and spiritual wellbeing of patients admitted at hospitals in Gaza Strip. Therefore, this study aims to assess if spiritual care is actually being provided to hospitalized cardiac patients who live in Gaza Strip, the barriers for providing such care, how these barriers can be overcome, and who should provide spiritual care to these patients.

The main interest of the researcher is to introduce the results of this research into the agenda of the health care policy and health education policy. Shafritz and Russell
(1999) and Gupta (2001) mentioned that introducing a topic to the agenda is the starting point of the policy process. Gupta further added that the cycle will not start unless the agenda is clear and captures the attention of policy makers. Although not everything needing new decisions on policy gains the attention of those would make it, the hope informing this study is that its findings will indeed attract the serious attention of health policy makers and health educators. It is hoped these findings will alert them to the importance of providing spiritual care to cardiac patients and the need to take practical steps toward establishing new health care and educational polices that address the provision of spiritual care to cardiac patients and eliminate barriers to providing such care to this group of patients.

Policy Implications

There are a number of different cardiac diseases. For that reason, their treatment options are different. Poor quality of life is associated with chronic heart diseases while the survival rates are worse than in breast and prostate cancer (NHS, 2009). Heart failure prevalence is predicted to rise within the next 20 years because of the increasing number of the elderly and ironically increased survival rate from heart attacks (NHS, 2009) and the number of deaths related to heart diseases in Gaza Strip has increased from 57.9 per 100,000 in year 2000 to 72.7 per 100,000 in 2010 (figure 1-2) (Ministry of Health-Gaza: Health Information Center, 2011, Ministry of Health, PHIC, 2011). Heart disease is associated with stress and anxiety. With the high levels of stressors that people living in Gaza Strip are exposed to, it is expected that the incidence of heart disease will increase.
Treatment options for cardiac patients include pharmaceutical, surgical, behavioral, or combined options (Smeltzer, Bare, Hinkle, and Cheever, 2008). However, several important surgical procedures are not available in Gaza. Therefore, providing spiritual care for cardiac patients admitted to hospitals in Gaza Strip may help to alleviate or decrease their stress, which may aid in improving their health and their quality of life and in decreasing the possibility for more cardiac complications and lowering the cost of their overall treatment.

One of the most important approaches to treat heart disease is associated with behavioral modification. Behavioral modification includes dietary changes, encouraging exercise, smoking cessation, reducing alcohol consumption, and promoting self-management (Smeltzer et al., 2008). Compliance with behavioral modification, based on
the theoretical framework supporting this study, can be basically influenced by spiritual wellbeing.

Because of the political situation prevailing in the area, including the blockade, many cardiac patients who were usually referred to receive treatment outside Gaza Strip are no longer able to leave the country. In fact, the blockade affected the drug and medical supplies that enter into Gaza Strip. For example, shortage of drug supplies ranged between 14-30% during blockade (World Health Organization: West Bank & Gaza, 2010). Lack of drug supplies and inability to travel outside Gaza Strip jeopardizes the life of cardiac patients and affects the quality of their life and the quality of care they receive. In fact, several patients died due specifically to issues related to the blockade. According to the Ministry of Health (2009), about 16% of the patients who died as a result of the blockade on Gaza Strip were patients diagnosed with heart disease.

Spiritual care is considered an essential component of the holistic approach of care (Murray, Kindall, Boyd, Worth, and Benton, 2004; Gray et al, 1994; Carson 1989) and it plays an important role in supporting the behavioral modification approach in treating cardiac patients and in reducing stress levels (Oates, 2004). Offering spiritual care could be very helpful in helping cardiac patients to control their diet, to exercise, and even to stop smoking. Such claims (supported by the findings of this research) hopefully will encourage the Palestinian Ministry of Health to take practical steps toward recognizing the importance of offering spiritual care in cardiac care units in the hospitals at Gaza Strip and encouraging health educators to incorporate spiritual needs into their curricula.
In terms of economy, the Palestinian Ministry of Health is under severe budgetary constraints. In spite of that, many patients with different diagnoses are referred to receive treatment outside the country. This is a necessary practice that drains the resources of the Ministry of Health. For example, according to the annual report of the Ministry of Health for the year 2010, the cost of referring 53,052 patients to receive treatment outside the facilities of the Ministry of Health (whether inside or outside the country) was 346,920,683 New Israeli Shekel (NIS) which accounted for 27.1% from the total budget for 2010 of 1,277,358,982 NIS (The exchange rate of the Israeli shekel in 2010 averaged 3.887 NIS). In the same year, a total number of 5,174 (2,947 from Gaza Strip) cardiac patients were referred to receive treatment outside the facilities of the Ministry of Health. The total cost of their treatment was 55,862,630 New Israeli Shekel (NIS) (16.1% of the total cost of referring all patients) (Ministry of Health, PHIC, 2011). Patients undergoing spiritual distress may consume more of the inpatient and outpatient services than others (Manning & Wells, 1992). Therefore, it is recommended to the Ministry of Health that it should pay more attention for providing spiritual care for patients in general and for cardiac patients in particular. Besides that, this study may contribute to reforming healthcare provider teaching and training plans to include spiritual care.

It is hoped that the results of this study and results of other future studies about the topic of spirituality will serve as a source of enlightenment for health policy makers and a motive for stakeholders to form advocacy groups which will have some power to inform and influence health policymakers. This can lead to introducing provision of spiritual care into the health care system in Gaza Strip, eliminating barriers to providing
spiritual care, and restructuring the health education curricula to incorporate spiritual care in training for future healthcare providers.

The process of enlightenment occurs over time and “accumulated research findings gradually alter decision-makers perceptions of both the causes of problems and the likely effects of policy interventions” (Stone, Maxwell, and Keating, 2001, p. 6). Furthermore, Sabatier and Wlible (2007) assumed that “scientific and technical information (results of research) plays an important role in modifying the beliefs of policy participants (p. 192). Therefore, the findings and conclusions of this study might be one first step in enlightening health policy makers along with other stakeholders about the barriers to providing spiritual care and the importance of providing such care to patients in general and to patients with cardiac problems in particular. When stakeholders have enough knowledge and information about the importance of providing spiritual care to cardiac patients, it is possible that they will form advocacy coalitions that will network with other important policy participants and seek allies with others who have similar core beliefs (Sabatier and Weible, 2007). Hopefully, such allies will have enough power to introduce this topic into the agenda of the health care policy that will lead to implementing a policy to provide spiritual care for cardiac patients admitted into cardiac care units (CCUs) in the hospitals of Gaza Strip.

Agenda setting is one of the most important steps in the policy process and it is the starting point of the policy process. Gupta (2001) and Shafritz and Russell (1999) put agenda settings at the beginning of the policy process or policy cycle. According to Gupta (2001), the policy process has the following six steps: agenda setting, policy formulation, policy adoption, policy implantation, policy evaluation, and policy change.
or policy termination. On the other hand, Shafritz and Russell (1999) identified five steps of the policy process which include agenda settings, policy decision or non-decision, policy implementation, policy regulation and feedback.

Gupta (2001) mentioned that the cycle of the policy process will not start if the agenda was not clear and that an issue should capture the government’s attention to be resolved. There are too many problems and issues (such as providing spiritual care for cardiac patients) looming in the society and waiting to be resolved. However, they do not capture the attention of policy makers and thus are not be included in agenda setting; consequently, the problem or issue will not be resolved. Of course, not everything that needs policy attention manages to gain it. But health of the people is a paramount issue.

It is hoped that the results of this study will be a source of enlightenment for health policy makers and other policy stakeholders in Gaza Strip. According to Sabatier and Jenkins-Smith (1998), interest groups and policy coalitions are important players who can play important roles in the determining agenda settings. Hopefully, the results of this study will be a motivator for the formation of advocacy coalitions that will network with health policy makers or practice pressure on them to push a policy about providing spiritual care as an integral recognized component of health care policy in the health care system of Gaza Strip.

Significance of the Study

Over recent years, there has been an agreement on the crucial need for spiritual care within the health care system, especially in the sphere of palliative care. Routine
spiritual assessment has been emphasized by policy, research, and practical guidelines for health care professionals as an important component of holistic health care (Murray et al., 2004). According to Wagner (1998), higher spiritual wellbeing is associated with routine assessment of the spiritual needs, including the spiritual aspect in the care plans.

As with most chronic illnesses, heart failure and other cardiac diseases can be managed or controlled but not cured (Taylor, 1999). Such diseases affect a broad area of human wellbeing including physical, emotional, social, and spiritual life (Timby, 2009). They also raise some issues regarding long-term medication, modification of life style, uncertain future, and even death (Rodes & Bowels, 2002). All of these issues can drive the patients to reevaluate their beliefs and question the meaning and purpose of their lives and other spiritual issues (Lancaster, 1997, Okon, 2005). Over the last three decades, research has been able to show an association between reduced risk of early mortality and frequent attendance at religious services (Larson, Larson, & Koeing, 2002). As a result of the advanced technology in modern medicine, the average life span increased and the process of dying slowed and was extended in time. As a consequence, “the end of life can last several years” (Puchalski, 2002, p. 289). Several studies asserted the growing need for spiritual care with aging (Moberg, 2005; Moberg, 1997; Missinne, 1980). In late stages of life, palliative treatment becomes a need to enhance the patients’ quality of life (Stewart & McMurray, 2002), where spiritual care is an essential aspect of palliative care (Oates, 2004). It is very important for the healthcare providers to understand such issues, obtain history, and be able to offer spiritual support for their patients (Okon, 2005). Stress, depression, and social isolation may not only delay the recovery of cardiac patients, but also may expose them to the risk of more complications and risks (Harvard
Men’s Health Watch, 2006). Therefore, prevention and relief of suffering must be considered a high-priority aim at the end stage of heart failure (Oates, 2004). Palliative treatment for cardiac patients should be able to address a patient’s spiritual needs, as part of holistic care, as a patient’s physical capabilities diminish and the lifespan is reduced (Oates, 2004). “The concept of the heart having spiritual significance through being the wellspring of one's’ spiritual essence could be considered to give the spiritual care of a patient with heart failure added importance” (Oates, 2004, p. 487).

By assessing the level of provided spiritual care to cardiac patients living in Gaza Strip, assessing their perception about the importance of providing spiritual care, and assessing their level of spiritual wellbeing, the researcher hopes to enlighten public health policy makers and call their attention about the importance of providing spiritual care to cardiac patients and to the lack of spiritual care provided to them and to other patients with different diagnoses. Such changes in health policy will have a major potential impact on the outcome, quality of care, and cost of care provided to these patients.

The researcher also hopes to call the attention of health educators to tailor their teaching curricula to incorporate teaching spiritual care. Lack of experience and inability to deal with spiritual issues (Kociszewski, 2004) and lack of preparation for nurses and other health care professionals to meet the spiritual needs of patients were cited by many studies as one of the major barriers to providing spiritual care (Orchard, 2000; Van Dover & Bacon, 2001; Feudtner, Haney & Dimmers, 2003; Fletcher, 2004; Koenig, 2004; Pronk, 2005; Kliwer & Saultz, 2006, Van Leeuwen, Tiesinga, Post, & Jochemsen, 2006; Burkhat & Hogan, 2008; Chan, 2009, McSherry & Jamieson, 2011). Therefore, incorporating spiritual care in the curricula of health education will prepare future
healthcare providers to be able to provide spiritual care and will equip them with a toolbox and competency for administering health care with a spiritual dimension to their clients.

Theoretical Framework

The theoretical framework of this study was integrated from the holistic approach of health, Parse's (1987) “Theory of Human Becoming”, and the revised “Health Promotion Model (HPM)” (Pender, Murdaugh, & Parsons, 2002). Holistic approaches posit that the human being is an integration of interrelated bio-psychosocial and spiritual components. Thus, any changes, whether positive or negative, in any aspect; will impact on the other aspects of health (Timby, 2009). Simultaneously, health status is continuously dynamic (WHO, 1998), and the human being moves back and forth on a health continuum, where wellness lies at one end of the continuum while death lies at the other end. The researcher imagines human wellness, with its various dynamic components, as a ship that sails in the health continuum sea (Figure 1-3). The goal of healthcare providers is to optimize the individual’s health by assessing his/her different health needs, including spiritual needs, and meeting these needs (ANA, 2003). Assessing and meeting the spiritual needs of patients, and in particular cardiac patients, can play a cardinal role in optimizing their health.

From a different point view, Parse's ‘Theory of Human Becoming’ plays a role in formulating the framework of this study. It presents an alternative to both the conventional bio-medical approach and the bio-psycho-social-spiritual approach of most
Figure 1-3: Theoretical Framework
other existing theories of nursing (Cody, 2012). Congruent with spirituality, this theory focuses on the depth of human experience and the process of unfolding of human becoming. Integrating the mind-body-soul connections is the main core of this theory.

This theory perceives the goal of nursing practice to be the achievement and maintenance of quality of life as described by each individual's own perception (Parse, 1998). Thus, the health providers (nurses) observe how individuals express a meaning of the situation, how they relate to close others, and the way in which they elucidate their hopes and wishes. All of these observations can help in modifying the health behaviors of the patients, including cardiac patients. The results of these modifications will be reflected in improving quality of life, decreasing suffering and minimizing stress, alleviating pain and reducing the need for pain medications, and congruently this can minimize the necessity to seek health services. As a result, the total number and time of hospitalization will be reduced. This will be reflected in decreasing the cost of the health care services provided.

According to Parse, healthcare providers should focus on the wellbeing, quality of life, meanings, inner awareness, and self-actualizations as the real dimensions of health. The application of Parse's theory enables healthcare providers, patients, and their families to reach the deepest experience of the human being and the “multidimensional healing” (Halm, Meyer, and Bennetts, 2000). Pares's(1987) ‘Theory of Becoming’ is “congruent with research involving spirituality and its role in health care compliance” (Black, Davis, Heathcotte, Nikki, and Sanderson, 2006).

The revised Health Promotion Model (HPM), the backbone of the theoretical framework for this study, was the source of inspiring the goal of promoting health of cardiac patients in Gaza Strip. HPM is built upon seven assumptions that emphasize the
ability of the persons to create their own unique living conditions that reflect their health potential. It proposes that health promotion involves taking actions that are directed towards promoting or maintaining individuals’ wellbeing. Therefore, individuals try to actively adjust their behaviors positively to promote their health. HPM attempts to “depict the multidimensional nature of the persons interacting with their interpersonal and physical environments as they pursue health” (Pender et al., 2002, p. 61).

Furthermore, the HPM assumes that “health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their lifespan” (Pender, et. al., 2002, p. 63) and that “health care providers are important sources of interpersonal influence that can increase or decrease commitment to and engagement in health-promoting behavior” (Pender, et. al., 2002, p. 64). These assumptions reflect the important role of physicians, nurses, and other healthcare providers in enhancing the spirituality of their patients. Thus, establishing a policy that mandates offering spiritual care may be the underlying cause of promoting the health of cardiac patients through reducing their stress, minimizing their pain, and modifying their behaviors and life styles.

Research Questions

This study is designed to answer the following questions:

1. According to the cardiac patients admitted to the cardiac care units (CCUs) in Gaza Strip’s hospitals, to what extent spiritual needs are provided?

2. To whom should the burden of providing spiritual care to cardiac patients admitted to CCUs in Gaza Strip’s hospitals be left?
3. What are the administrative/organizational barriers to providing spiritual care to cardiac patients admitted to CCUs in Gaza Strip’s hospitals?

4. What can be done to remove barriers to provide spiritual care and increase the frequency of providing spiritual care to cardiac patients admitted to CCUs in Gaza Strip’s hospitals?

Summary

Heart disease is the most common cause of death among the Palestinian population. There are several treatment options for heart diseases. These options include medical, surgical, and behavioral modification options. With the negative impact of stress on the prognosis of heart disease, it is believed that spiritual care can reduce stress levels and help patients to adopt some behavioral changes, such as stopping smoking, diet modification, and exercise. It is also believed that spiritual care can help in improving patient readiness to adhere to and comply with their treatment options, which will have positive impact on their health, quality of life, and prognosis.

Recently, it has been reported in the literature that there is a growing concern about providing spiritual care for patients (especially patients diagnosed with cancer and HIV and patients needing palliative care at the end of life) as an essential part of the holistic care approach. Several studies supported the positive association between the provision of spiritual care and health. However, there is no agreement regarding the definition of spirituality, which is considered a complicated issue. In the available
literature, there is a major debate about distinguishing spirituality from religion. From the perspective of Islam, spirituality is embedded within religion and unity of God.

This study is designed to assess whether spiritual care is provided to cardiac patients admitted to cardiac care units in Gaza Strip hospitals or not, the barriers to provide such care to these patients, to explore what can be done to remove these barriers to provide spiritual care to patients diagnosed with heart disease and to ascertain who should best provide spiritual care to this group of patients.

It is hoped that the findings of this study can serve to enlighten health policy makers about the importance of providing spiritual care and therefore the need to adopt new health policies aimed at providing spiritual care for cardiac patients and the need to eliminate barriers to providing spiritual care for these patients. Providing such care is expected to promote patients' health, improve their quality of life, and decrease the cost of their treatment. It is also hoped that the results of this study will motivate health care educators to incorporate spirituality and spiritual care in their curricula to prepare future healthcare providers for providing such care to their patients.
CHAPTER II
LITERATURE REVIEW

This chapter encompasses several sections of literature review pertinent to the content and focus of this dissertation study. This involves a general background about the Palestinian health care system and policy process, definition of spirituality, spirituality and religion, spirituality in health care, spirituality in health education, and the barriers that may limit provision of spiritual care. In addition, this review of the literature also covers how different religions, including Islam, look at the dimension of spirituality in health. Finally, this chapter also reviews several studies that evolved looking at spirituality in health care from the perception of patients and of healthcare providers, along with a number of studies on aspects of spirituality among patients with heart disease.

Health Care System, Health Status, and Health Policy in Gaza Strip

The health care system and health policy in Gaza Strip is a novice system. The health sector in Palestine, including Gaza Strip and West Bank became independent from the Israeli health care system and health policy in 1994.
A health care system is defined by the WHO (2000) as “all the activities whose primary purpose is to promote, restore or maintain health” (p. 5). In general, to be successful, systems involve integrated subsystems and are adaptive to the surrounding environment. Without adaptation, the system will face chaos and consequent failure (Janecka, 2009). Usually a health care system does not function in vacuum. It is affected by political, socioeconomic, and cultural factors (Saltman, 1999). Successful health care systems should be able to achieve their main objectives, which include improving the population’s health status, responding to the population’s expectations, and financially protecting the patients against the expensive costs of health services (WHO, 2000, p. 8). Inability to meet these objectives usually results in public dissatisfaction with the local health care systems (WHO, 2000).

The components of the health care system vary widely. The major three components are: clients receiving health services, professionals offering health care services, and health care institutions and how they regulate, organize, finance and coordinate these services (Library Index, 2009). In addition, others have argued that accessibility, affordability, equitability, sustainability, and good quality are essential components of any liable health care system (Meadowcroft, 2008 & WHO, 2000).

“Health systems are undergoing rapid change and the requirements for conforming to the new challenges of changing demographics, disease patterns, emerging and re-emerging diseases coupled with rising costs of health care delivery have forced a comprehensive review of health systems and their functioning” (WHO-EMRO, 2007).
Several issues; including financing health care, human resource imbalances, access and quality of health services, significantly affect the ability of health systems to deliver the required services (WHO-EMRO, 2007). The Palestinian health care system is financed by several resources. The donations from other countries form a critical part of the Ministry's of Health budget (Hamdan & Defever, 2002).

*The Health Care System in Gaza Strip*

The case of the health care system in Gaza Strip is unique. Before the establishment of the Palestinian National Authority (PNA) in 1994, the Palestinian health care system was completely dependent on the Israeli system. Power and authority to control the health department were owned by the Israeli administration. According to a report of the WHO, in 1989 the health care system in Palestine in general and in Gaza in particular was “disturbing” (World Health Organization, 2001). Taking into consideration the political condition; especially during the first Intifada (1987-1994), this was an expected consequence of dependency on the Israeli system and lack of their own organizational structure within the health care system (WHO, 2000). The Palestinian-Israeli conflict dramatically affects the life of people who live in Gaza Strip and the health care system. Thousands of deaths, injuries, disabilities and mental illnesses were the results of this conflict. In general, the health care system was overwhelmed (Hamdan & Defenver, 2002).

Within the health care system (HCS) in Palestine, there are four health providers: the government represented by the Ministry of Health, the United Nations Relief and
Work Agency (UNRWA), the non-governmental organizations (NGOs), and the private sector (Ministry of Health, 2005a, WHO-EMRO, 2007). The Ministry of Health is considered the main healthcare provider in Palestine followed by the UNRWA, which covers 1,635,000 refugees (Ministry of Health, 2005a). Refugees (those who were expelled by the Israelis from their cities and villages after the war of 1948) form 73.1% of Gaza Strip residents (WHO, 2006). Most NGOs offer services for small fees while clients pay for the health services in the private sector. Generally, the Ministry of Health provides primary, secondary and tertiary health services and purchases the unavailable tertiary health services from local or outside the country facilities. In the main, UNRWA provides primary health care services just for refugees and purchases secondary care services when needed. NGOs provide primary, secondary, and some tertiary services. The three levels of care are provided by the for-profit private sector (WHO-EMRO, 2007). However, the Ministry of Health has official responsibility for the health system. For the success of any health care system, it should be able to integrate all its subsystems into the large health care system (Janecka, 2009). In spite of the fact that that the Ministry's of Health annual report for 2004 stated that the health facility network in Palestine is well-developed (Ministry of Health, 2005a), this is not the case at the moment, particularly inside the blockaded Gaza Strip. There is no regulation controlling the activities of the private sector except for a relatively poor licensing policy for private clinics and health institutions (WHO-EMRO, 2007). Furthermore, a report that was prepared by the RAND Palestinian State Study Team (2007) mentioned that there was a lack of coordination between Gaza Strip and West Bank on the one hand and the four
health providers on the other regarding implementing health programs and health policies.

In the year 2009, there were 27 hospitals in Gaza Strip. The Ministry of Health operates 13 of them with a total capacity of about 1,500 beds. Additionally, 500 beds are operated by private and NGO sectors (WHO, 2009). Regarding the hospitals, the Ministry of Health is the principal provider since the main focus of the UNRWA is directed to Primary Health Care (PHC) services (Ministry of Health, 2005a). In general, the bed/population ratio in Palestine is 15.4 beds per 10,000 populations. This ratio is one of the lowest ratios in the region, if compared with Egypt (21/10,000), Jordan (18/10,000), and Syria (14/10,000) (Ministry of Health, 2005a).

Some hospitals are specialized, with pediatric, psychiatric, obstetric, and ophthalmic hospitals. Others are general hospitals that provide medical and surgical care. Almost all general hospitals can treat patients with cardiac problems, but there are three main facilities, namely Shifa, Nasser and Shuhada Al-Aqsa Hospitals, that have coronary care units for acute heart problems. In addition, there is a unit at the Gaza European Hospital for cardiac catheterization.

Palestinian Health Care System Rules, Regulations and Policies

Health policy is defined as “the way nations, states, cities, and communities distribute resources to competing interventions and competing populations based primarily on anticipated benefits. Health policy reflects the values of the society or community in terms of how and to whom health resources are distributed” (Patrick &
Erickson, 1993, p. 419) and as “a program of action whose aim is to improve health conditions of the people” (Neema, 2005, p. 2). Hamdan & Defever (2002) add that the development of health policy is “a dialectic process between the policy process itself and the context within which it is formulated” (Hamdan & Defever, 2002). In order to have a successful policy decision-making or policy analysis, it is important to understand the policy context (Collins, Green, & Hunter, 1999). Garvin and Eyles (2001) add that health policy should be adaptive to the circumstances of the health needs and objectives of each country. Most health policies are set to meet the objectives and needs of the community regarding maintaining, promoting, or restoring the community’s health (Gunning-Schepers & Stronks, 1999).

During the period of Israeli occupation (1967-1994), almost all the policies were set by Israelis, except a very tiny Palestinian participation such as the “Child Health Committee in Gaza” and the “1985 Adler Committee on Health Planning for the West Bank” (Rand, 2007, p. 243). When the Palestinian Ministry of Health took charge of planning for health care after the establishment of the Palestinian National Authority, decision-making for health policy was fragmented, distributed between the major four health providers in Palestine, which are the Ministry of Health, UNRWA, NGOs, and the private sector. Furthermore, there was a fragmentation of decision-making between the four providers in the West Bank and their counterparts in Gaza Strip (Barghoutis and Lennock, 1997, as cited by Mataria, et al., 2004). The planning for UNRWA was mainly conducted at UNRWA’s headquarters in Vienna with some participation of Palestinians. The only well-documented law, found on the Ministry's of Health website, is the Public Health Law, article 20. It was established in 2004 and published in April 2005. This law
covers several issues, such as birth and death registration, maternal health, abortion, food monitoring, prevention and control of communicable diseases, and dispensing medicines (The Rand Palestinian State Study Team, 2007). The disruption due to the Palestinian-Israeli conflict affected the ability of the Ministry of Health to accomplish its objectives. Therefore, most of the objectives were mentioned in the first strategic national health plan in 1994 were not met; thus, the same objectives were repeated in the second plan issued in 1999 (The RAND Palestinian State Study Team, 2007).

“Patient referral is one of the main challenges facing the health system. The Ministry's of Health previously well-functioning referral system (in 2007 alone, some 9,000 patients in Gaza were referred for treatment abroad) had been disrupted. Patients’ referrals are currently being arranged by the ICRC and the PRCS, in consultation with the Ministry of Health” (WHO, 2009a, p. 2). The referral policy had some criticism. For example, Abed (2007) concluded that the referral policy was weakly enforced. Some of the cases that were treated abroad at a higher level could be treated locally at the Ministry's of Health facilities at lower costs.

One of the most prioritized agenda of the WHO strategic plan in 2006-2008 was to “support development of adequate and appropriate health policy, considering macroeconomics and social determinants of health” (WHO, 2006, p.2). Decision-makers at all levels need to appraise the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings. Meaningful, comparable information on health system performance, and on key factors that explain performance variation can strengthen the scientific foundations of health policy at international and national levels. Comparison of performance across
countries and over time can provide important insights into policies that improve performance and those that do not (WHO-EMRO, 2007).

To improve the efficiency, development, and implementation of health policy in Palestine, several related reports have included several recommendations. Some of the recommendations in these reports were to enhance the coordination among the four parties that provide health care and between Gaza Strip and West bank regarding planning and policy development and implementation. Other recommendations included developing and enforcing polices related to accreditation of health care facilities and regulating their work, accreditation of schools educating health professional and their programs, licensing of health care professionals, and regulating and controlling policy for referring patients for treatment abroad (Abed, 2007; The RAND Palestinian State Study Team, 2007; World Health Organization, 2005).

*Effect of Siege and the Last War (Dec. 2008-Jan. 2009) on the Health Care System in Gaza Strip*

In Gaza Strip, about 1.5 million individuals live in an area of 3,605 km\(^2\) (Ministry of Health, 2004). Siege has been imposed on Gaza Strip since 2006. Blockade did not include only the restriction of the movement of people and goods, but also involved limiting fuel and electricity supplies to Gaza Strip. Furthermore, hospitals and health care facilities were forced to receive emergency cases only during war time. For example, 24 Primary Health Care Centers (PHCC) from the 56 centers operated by the Ministry of Health were functioning as emergency centers in the time of hostilities. Several PHCC
staff was reassigned to work at hospitals. Some PHC centers were damaged; while others just functioned intermittently because of their proximity to areas considered to be of high risk (WHO, 2009). In addition, the case of the war added more restrictions to the movement of the people living in Gaza Strip, which affected the movement of patients to travel outside Gaza to receive treatment if they cannot find such treatment in Gaza Strip (figure 2-1). This also affected the movement of goods and medicine into Gaza. As a result, the Ministry of Health used to report severe deficits in the drugs and medical supplies. Cardiac, oncology, and renal failure patients formed the greatest portion of those patients needed to be referred abroad. The health care system in Gaza is not adequately prepared to satisfy the needs of these cases which negatively impacted the quality of their lives (WHO, 2009).

Attacking one of the world’s most densely populated spaces, and killing more than 1,300 persons while injuring more than 5,000 within three weeks, were sufficient to exhaust any health care system (WHO, 2009). The public media and the WHO reported that health professionals had to work continuously to deal with the casualties (WHO, 2009). Limited electricity and fuel supplies at that time could seriously affect infection control, blood transfusion, and basic sanitation in the operating rooms and the intensive care units (WHO, 2009).

During and after the war, almost 28,116 inhabitants were displaced. Those people were left without any basic needs provision such as health care, safe water, food, basic sanitation and hygiene (WHO, 2009). In addition, it could be argued that living in camps and tents in the cold weather in Gaza during the winter made those people vulnerable to health impairment and crises, including colds, communicable diseases, and chronic
diseases, as well as psychological and spiritual suffering. Furthermore, the WHO report (2009) warned that “the physical and mental trauma of the civilian population in Gaza, the continuing and prolonged disruption of basic health services, and the added burden of displacement, are compounded by the increased risk of communicable diseases” (pp. 1-2).

Spirituality and Health

Historically, medicine and spirituality were closely intertwined and usually, the healers were the same persons as the priests or the religious leaders. They used to take care of the body and the spirit of the ill persons in order to heal them from their illnesses. The role of the religious leader was fused with the role of the healer (Greenberg, 2003).
Definition of Spirituality

“The word ‘spirit’ in Greek culture is contrasting to body and material reality. In modern Western cultures, a spiritual person is the one who is impartial in material gain or worldly concerns. In Hebrew, spirit is opposed to death, destruction and negative aspects of the law, such as obligation, fear and punishment. Spirit is understood to be within the body; providing the life force, acting through it, and motivating action” (Golberg, 1998, p. 837).

Reviewing a considerable portion of the literature regarding spirituality makes it very clear that one of the greatest challenges associated with this issue are the fragmented definition of “spirituality” and the absence of common agreement about a single clear definition. In spite of that, there is an agreement about the importance of considering spirituality in health care (Chaturvedi, 2007; McSherry & Ross, 2002; Mako, Galek, Poppito, 2006; O’Connor, Guilfoyle, Breen, Mukhardt, & Fisher, 2007; Larson, Larson, & Koenig, 2002; Levin, Chatters, & Taylor, 2005). But the term is still ambiguous and lacks a clear definition and understanding (McSherry & Ross, 2002), since there is some kind of non-distinction between spirituality on the one hand, and the emotional and psychological aspects on the other (Halm, Myers, & Bennett, 2000).

At the same time, many debates exist regarding whether spirituality differs from religion or not (Harrison, 1993; Kearney & Mount, 2000; Rumbold, 2003; McGrath, 2004; Speck, Higginson, & Addington-Hall, 2004; Chaturvedi, 2007). Although spirituality promotes developing a relationship with a Higher Power such as God (Burkhardt, 1994; Goddard, 1995; Meraviglia, 1999), some researchers who believe in
the difference between spirituality and religion think that spirituality is broader than
religion (Stoll & Stoll, 1989). Congruently, Narayanasamy (2004) has argued that along
with prayer to God, spirituality also encompasses meaning, purpose, and connections
with others.

Spirituality can be perceived as a process of meaning-making (McGrath, 2004)
while religion, on the other hand, is seen as "a construct of human making that . . .
enables conceptualization and expression of spirituality” (Kearney and Mount, 2000, p.
359). A person can be spiritual (seeking self-awareness, self-empowerment and self-
actualization) but without affiliation to any religious group or Higher Power (Carson,
1989). Rumbold (2003) has argued that spirituality is personal and unique and might
encompass religion for some individuals, but not for others. Beyond religious affiliation,
spirituality can be perceived as “the effort exerted by individuals as their inspiration,
reverence, awe, meaning and purpose, regardless of their belief or lack of belief in
supreme deity” (Hardin, Hussey, & Steele, 2003). Walton (1999) argued that the concepts
for unifying force, connectedness, search for meaning and purpose, and the relationship
with self, others, higher power and nature, are all the components of the spiritual
dimension. Smith (1994) identified four dimensions of spirituality: meaningfulness of
life, positive potential of all aspects of life, awareness of interconnectedness of life, and
beneficial nature of contact with a transcendent dimension. Several authors (Labun, 1988;
Saunders, 1988; Carson, 1989; Kellheear, 2000) defined spirituality as the search for
existential meaning, a motive that impels human beings forward in their lives and is not
always expressed through religion.
From a different vantage, impaired spiritual wellbeing may be associated with spiritual pain. Tamura, Ichihara, Maetaki, Takayama, Tanisawa, & Ikenaga (2006, p. 180) mention that spiritual pain is “caused by extinction of the being and meaning of the self.” Spiritual pain may manifest itself as symptoms in any area of a person’s experience, including symptoms ranging from physical (e.g., intractable pain), psychological (e.g., anxiety, depression, hopelessness), religious (e.g., crisis of faith) to social (e.g., disintegration of human relationships). However, it is not possible to recognize spiritual pain on the basis of symptoms alone. It is the combination of the symptoms with characteristic descriptions and behaviors that helps to identify this form of suffering (Kearney and Mount, 2000). On the other hand, Cassell (1982) mentioned that “suffering is experienced by persons, not merely by bodies, and has its source in challenges that threaten the intactness of the person as a complex social and psychological entity. Suffering can include physical pain but is by no means limited to it” (p. 639). Other authors defined spiritual needs as “any need related to a person’s belief, practices, habits, norms, customs, and rituals” (Margo; Russell & Patrice, 2000, p. 54).

Therefore, spiritual care is defined by Lunn (2003) as “meeting people where they are and assisting them in connecting or reconnecting to things, practices, ideas, and principles that are at their core of their being--the breath of their life, making a connection between yourself and that person” (p. 154).

It is clearly recognized that there is an embedded difficulty in the West with the synergy of spirituality and religious beliefs (Rasool, 2000). According to Fahlberg & Fahlberg (1991), the difficulty of defining spirituality is related to its association with both religion and cultural emphasis on the material field.
In nursing, several authors attempted to define spirituality as a holistic dimension (Carson 1989, Shelley & Fish 1988). Murray and Zentner (1989, p. 259) defined the spiritual dimension as “a quality that goes beyond religious affiliation that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any God.” The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death (Murray & Zentner 1989, p. 259). There are some things inherent in spirituality, such as the aspect of becoming more aware of one’s own being and life source. Some of the indicators of spirituality might be a sense of purpose, hopefulness, creativity, joy, enthusiasm, courage, flowing easily with change, reverence, awe, humor, serenity, sharing with others, and providing meaning in struggle and suffering, to name but a few (Carson 1989; Shelley & Fish, 1988; Salladay & McDonnel, 1989).

**Spirituality in Health Care Policy**

Recently, there has been an increased acknowledgement of holistic care, since all the systems, with all their components; biological, psychological, social, and spiritual -- cannot be viewed in isolation of each other. Therefore, spiritual care is considered an essential component of the holistic approach of care (Murray, Kindall, Boyd, Worth, and Benton, 2004; Gray et al, 1994; Carson 1989). As a result, healthcare providers strive to adopt a holism philosophy by providing a holistic care for their clients. Several decades ago, Carson (1989) argued that holistic care cannot exist without the spiritual aspect,
which gives persons their 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 (McSherry, 1983). In the last few years, healthcare providers and health care policies have started to acknowledge the importance of spirituality and spiritual care for the wellbeing of their clients.

In the large number of research studies conducted on spirituality, which showed that spiritual care is associated with decreased anxiety, depression, psychological distress (Mickley & Soeken, 1993; Tuck, et al., 2001; Thoresen & Harris 2002), and reducing the risk of early mortality (Larson, et al., 2002), it was also noticed that spirituality was a core of several health polices over the last two decades in some countries and health care systems. The core of spiritual care policy was directed toward enabling staff and improving their competencies in assessing and meeting the spiritual needs of their clients. That can result in reducing the length and decreasing the frequency of hospitalization, reducing pain and the need for pain medication, lowering stress levels, reducing the demand on healthcare providers, and improving patient satisfaction (Bradford Teaching Hospitals NHS Foundation Trust, 2011).

Over the last few years, there has been agreement on the crucial need for spiritual care within the health care system, especially in palliative care. Routine spiritual assessment has been emphasized by policy, research, and practical guidelines for health care professionals as an important component of holistic health care (Murray et al, 2004). As a result, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recognized that patients’ “psychosocial, spiritual and cultural values affect how they respond to their care” (Joint Commission Resources, 2003, p. RI-8) and has
concentrated on spirituality and emotional wellbeing 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 (Gray, Steele, Sweeney, and Evans, 1994).

Reviewing the literature related to spirituality in the health care systems showed that “America is leading the way in exploring the concept of spirituality and establishing its importance in holistic care,” while the British began later on to devote more attention to this issue (Oldnall, 1996, p.23). At the time being, several hospitals in some Western countries offer spiritual care by chaplains, at least when requested (Clark, Drain, and Malone, 2003). But in Gaza Strip, such services are not available. Almost no formal spiritual care is provided at the hospitals or other health care facilities.

Recently more attention has been paid to spiritual care. It has attracted the heightened attention of researchers, health care professionals and educators over the last 25 years (Murray, Kendall, Boyd, Worth, and Benton, 2004). The relationship between spirituality and illness is at the center of a growing body of literature (Kaey & Raghavan, 2002) and there is little disagreement now in the health care policy arena about including spiritual care in the treatment process (Handzo and Koenig, 2004). As a result, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recognized that patients’ “psychosocial, spiritual and cultural values affect how they respond to their care” (Joint Commission Resources, 2003, p. RI-8) and has concentrated on spirituality and emotional wellbeing 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 (Gray, Steele, Sweeney, and Evans, 1994). Therefore, JACHO and the Commission on Accreditation of Rehabilitation Facilities (CARF) requires that
healthcare providers should assess and meet patients’ spiritual beliefs, practices, and needs (Clark, Drain, & Malone, 2003). Many other countries followed in the footsteps of the United States and implemented a policy that mandates healthcare providers to provide spiritual care to their clients. Examples of these countries include the United Kingdom (National Association of Health Authorities and Trusts, 1996; Nursing and Midwifery Council, 2002; Department of Health, 2003; National Institute for Health and Clinical Excellence (NICE), 2004; Multi-Faith Group For Healthcare Chaplaincy, 2006), Scotland (Scottish Government 2009), Norway (Norwegian Nursing Association, 2001), Malta (Malta Code of Ethics, 1997), and recently Israel (Bentur, Resnitzky, Sterne, 2010).

**Spirituality, Health Care, and Religions**

Historically, nursing was viewed as a job of service that incorporates a clearly accepted mission to those for whom the nurse cared. Altruism and empathy for the sick were the basis of the nurse’s mission. Therefore, nurses cared for patients without expecting much of the worldly reward for their efforts until the middle of the 20th century. Nurses envisioned caring for the ill, especially the sick poor, as commissioned and supported by God, since most of the nurses were affiliated with different religious institutions. For example, up to a few decades ago, most nurses were nuns and monks in Christian countries and most nursing schools were affiliated with different churches, which reflects how much religion was interwoven with spirituality and health (O'Brien, 1999).
Since the beginning of human history, when someone gets sick, people around him/her have always attempted to provide two functions: caring for that ill person and attempting to cure the sickness. As most diseases were considered a punishment from God, providing spiritual care was considered as a means for helping these ill persons to be cured and was a motive for others to care for them. Therefore, spirituality was linked with caring and curing since earliest times (Barnum, 2003). Barnum reviewed the history of spirituality in health by various religious groups, starting from shamanism, the first group that linked altered level of consciousness with religion and used spiritual care to help the unconscious to regain consciousness. Barnum followed the history of practicing spiritual care as a religious tool for curing in the pre-Christ era (Greek and ancient Egyptians). She mentioned that the mystery schools which were founded in Athens earlier than 1,500 B.C. used altered states of consciousness to achieve their goals. But these schools were cloaked in secrecy; therefore, it is not known what methods they used to induce these altered states. But, during the altered state of consciousness, ill persons “received healing dreams. Sometimes; Aesculapius, the classical God of Medicine, appeared in such visions” (Barnum, p. 25).

In the Greco-Roman era, families and sometimes slaves used to nurse the ill family members and provide spiritual care to them. Support was perceived as a duty to and a sign of love for that sick family member (Swaffield, 1988, p. 2830 as cited by O’Brien, 1999). Hippocrates, the consummate ancient Greek physician, instructed caregivers to "use their eyes and ears, and to reason from facts rather than from gratuitous assumptions" (Deloughery, 1977, p. 8 as cited by O’Brien, 1999). Nursing the sick was also influenced by spirituality by the Romans and they used prayers to gods and
goddesses as important adjunct therapy in nursing their patient (O'Brien, 1999). For the Hebrew people of Israel, spirituality was also influenced by religion and many Mosaic laws were concerned with providing care to the ill. There were many prohibitions related to hygiene and general health and rules related to cleanliness, diet, and hours of work and rest (Sellew & Nuesse, 1946 as cited by O’Brien, 1999).

In Christianity, nurses used religious behavior in treating their patients (Barnum, 2003). Nursing the sick or injured people was honored and respected as one of the primary messages of Jesus was 'to love one’s neighbor.' Jesus, who gave attention to others needs by touching, anointing, and holding the hand, was a role model for his followers in serving the ill brothers and sisters and proving them care that incorporates love and tenderness (O’Brien, 1999).

In the era of the Crusades, many shelters, hospitals, and monasteries were built along the roads of pilgrimage to Jerusalem. These hospitals provided care and service to the sick (Pavey, 1959 as cited by Barnum, 2003). Many religious, spiritual therapies were offered to the sick that had a religious basis. Among the spiritual therapies used at that time were “prayer, contemplation, fasting and other methods of self-temperance, music, chanting, encouraging the patient in his faith, arranging for religious rites, spiritual counseling, reading the Bible or other religious materials, praying for or with the patient, worshiping, and discussing and seeking the purpose and meaning of life” (Barnum, 2003, p. 163).

In Islam, an important concept is Unity or Tawheed, “which means faith in the total Lordship of Allah as ruler of heaven and earth”; allied with this concept is the understanding that one's life must be centered on this belief (Abdil-haqq Muhammad,
Other important religious practices for Muslims include praying five times a day, fasting the month of Ramadan, paying zakatt (giving 2.5% of their money to the poor each year) and performing hajj, a pilgrimage to Mecca in Saudi Arabia once in a lifetime (O’Brien, 1999). Further explanation about spirituality in Islam will be discussed in a separate section.

Regardless of the patient’s faith, Barnum, (2003 p. 165) suggested six religious therapies to help nurses in providing spiritual care and support to their clients. These therapies include: “(1) prayer, (2) presencing, (3) religious contemplation, (4) ritual, (5) giving meaning to illness and suffering, and (6) helping the patient maintain faith.”

Because “faith is an important spiritual therapy for many patients” (O’Brien, 1999, p. 172), spirituality was highly connected with religion with the foundation of modern nursing by Florence Nightingale in the 19th century. According to Nightingale (1860/1994), spirituality is the experience of individual’s unity with the divine power and consciousness that underlies the created world. She added that religion is “the tie, the binding, or connexion between the Perfect and the imperfect, the eternal and the temporal, the infinite and the finite, the universal and the individual” (Nightingale 1860/1994, p. 23). Therefore, nurses used not to differentiate between the concepts of religion and spirituality. As a result, most of the tools that were developed by nurses to assess spiritual wellbeing incorporated religious assumptions (Hood Morris, 1996), and most of the spiritual care offered by nurses to their clients included prayers or referral to a clergyman (Stranahan, 2001; Taylor, Highfield, & Amenta, 1999).

Although there is an overlapping between religion and spirituality, according to several authors, they are not synonymous (Dyson, Cobb, & Forman, 1997; McSherry &
Draper, 1998; Peterson, 2000; Burkhardt & Nagai-Jacobson, 2002). Recently, some British hospitals provided spiritual care in a broader and a different perspective, since spirituality was seen as what the patient thinks is meaningful for his/her life (Walter, 1996). Therefore, nurses started to move from the conventional approach of providing spiritual care that was connected to religion and began to redefine spirituality to include a social perspective; more attention was also given to the Divine as a value or principle which gives purpose and meaning (Coyle, 2002). Hall (1998) added that nurses began to change their understanding of spirituality to incorporate intrapersonal and interpersonal aspects. The intrapersonal aspect of spirituality includes facilitating self-potential, inner strength, and knowledge. The interpersonal aspect includes interaction with the natural world and other humans (Narayanasamy, 1999a). As the definition of spirituality broadens, nurses need to keep up with the evolving spiritual needs of their patients regardless of their religion and beliefs.

**Spirituality, Health, and Islam**

As in other religions, spirituality is part of Islam. In fact, Rasool (2000, p. 1479) emphasized the impossibility of separating spirituality from religion since “the concept of religion is embedded in the umbrella of spirituality.” In the perception of Islam, the human being is the most worthy creature in this world and other things were created for the sake of human beings. Not only does Islam pay great attention to physical health, it also focuses on the spiritual component of the human being. Islam views the human being as a triangle consisting of body, psyche, and spirit, and these three parts are
interrelated. The word “Islam originates from the root word 'salama' which means getting free of inward evils” (Stacy, 2008, paragraph 1). This consequently leads to the essence of spiritual health and peace reconciliation in Islam. Islam sets effective laws to protect health and the body by keeping it sound and free from illness, impurities and filth. It lays stress on hygiene, and the need to keep body and soul in a healthy state. It forbids all means of self-destruction such as adultery, sodomy, eating pork and carrion, drinking wine and blood. Islam also frowns upon gluttony so as to ensure health and happiness (Stacy, 2008a).

Therefore, “Islamic teachings and practice have enabled the production of a holistic framework in meeting the physical, spiritual, psycho-social and environmental needs of individuals and communities” (Rasool, 2000, p. 1476). Based on the Quran and guidance of the Prophet Mohammed (Peace Be Upon Him {PBUH}), spirituality in Islam is built upon the ‘unity’ or ‘tawheed’, which means believing that there is no God except Allah. Muslims recognize the presence of the Divine and they inquire about “meaning, purpose and happiness” in both lives (worldly life and the life after death) (Rasool, 2000, p. 1479). According to Rahman (1980, p. 253 as cited by Rasool, 2000), the spiritual discipline, which “educates and trains the inner self of man is the core of the Islamic system. It also frees man from the slavery of the ‘self’, purges his soul from the lust of materialistic life and instills in humans a passion of love for Allah. It is through the process of patience, perseverance and gratitude that opens the door for spiritual and physical well-being.”

Islam pays great attention to health. Although the Quran, the Holy Book of Muslims, is not a medical book, it gives several guidelines for health and treatment.
According to El Kadi (1993), the Holy Quran has a clear positive influence on health, either through curing from illnesses or promoting health. As Muslims strive to obey God, they adhere to his guidance in life, including aspects related to health. Prophet Mohammed (PBUH) taught Muslims that “your body has rights over you,” which means that Muslims are responsible to protect their health. Also he said: “Ask Allah for forgiveness and wellbeing.” General wellbeing includes all aspects of health. Therefore, seeking medical treatment is encouraged in Islam and is not considered as a sign of conflict with confidence in Allah for a cure. Prophet Muhammad said: “Seek treatment, because Allah did not create a sickness but has created a treatment for it except for old age” (Rasool, 2000). According to Al-Jibaly (1998), an un-well Muslim should keep in mind that his or her sickness is a check coming from Allah; it brings tidings of forgiveness and mercy to the person afflicted. Thus, avoiding complaint about such suffering, accepting it with patience and satisfaction, and asking Allah to reduce this distress are highly encouraged (Rasool, 2000).

Medicine, prayers, fasting, *hujamah* (cupping) and *ruqya* (spelling or reciting the Quran over the sick for the purpose of treatment) are all considered methods for remedy in Islam. Although a Muslim can visit physicians to seek treatment for illnesses, they believe that physicians are just tools, and the final result is only made by Allah. Such a belief permits Muslims to live in genuine spiritual peace (Kasule, 2007).

From a different aspect, Athar (1993& 1998) stated that Muslim patients consider an illness as atonement, rather than punishment for their sins, and death as part of a journey to meet their God. For Muslims, experiencing a disease(s) is a normal part of the natural life. For that reason, Muslims who recognize this cannot embark on questioning
God’s love, why this happens, or question the purpose of life. Muslims always should thank God for everything, whether it is perceived as a bad or a good event, as the Prophet (PBUH) stated: “The reality is that God is just, therefore, whatever situation a believer finds himself in, he knows there is goodness and wisdom embedded in it” (Stacy, 2008, para. 6).

General health advice is offered by Islam, either in the Quran or Sunnah (Prophet Mohammed guidance). Taking care of hygiene, diet, safe sex, avoiding accidents (such as fire and poisoning), and even isolating patients with infectious diseases are all emphasized in Islam. Islam prohibits drinking alcohol, eating pork and the meat of animals slaughtered after they died, ingesting blood, and smoking. A healthy diet relates to the interconnectedness of physical and spiritual health. “Healthy eating not only satisfies hunger but also has an effect on how well we worship” (Stacy, 2008a, para. 7).

In general, anything that may negatively affect a Muslim’s health is forbidden, since Prophet Mohammad encouraged avoiding anything that might bring harm. There should be neither causing harming nor reciprocating it (Nawawi, 2009). This encompasses causing harm to any aspect of health, which includes physiological, psychological, spiritual, and emotional aspects.

Additionally, Muslim physicians made an important contribution regarding spirituality. The range of treatment practiced by the physicians in Islam extended from freckle lotion to psychotherapy. Though freckles continue to sprinkle the skin of 20th century, in the realm of psychosomatic disorders, both al-Razi and Ibn Sina achieved dramatic results, antedating Freud and Jung by a thousand years. Al-Razi combined psychological methods and physiological explanations and he used psychotherapy in a
dynamic fashion. The Arabs brought a refreshing spirit of dispassionate clarity into psychiatry. In addition to baths, drugs, music therapy and occupational therapy were also employed. These therapies were highly developed. Special choirs and live music bands were brought daily to entertain the patients by providing singing and musical performances and comic performers as well (Abuelaish, 1993).

Spiritual support was also offered by the first Muslim nurses. After the establishment of the Islamic State in Madinah in Saudi Arabia, Rufaidah Al Ansareyah (who is considered the first professional nurse in Islam) devoted herself to nurse the sick Muslims. Prophet Mohammad (PBUH) offered a tent, outside his mosque, to nurse sick Muslims in peace time. During war time, she used to guide a group of helper nurses who went to the battlefield and treated the wounded soldiers. Rufaidah trained a group of women companions as nurses. She and her team members of volunteer nurses used to have a special tent during war time that was used as a field hospital. They were able to perform several tasks during the war, such as providing water for the sick, caring for wounded soldiers and offering medicine to them, and taking care of the deceased and transporting them to the Madinah (Qasule, 1998, Miller, 2007). As appreciation for her efforts, the Prophet (PBUH) assigned her a share of the booty that was equivalent to that of the soldiers who had actually fought in the battle. During peace time, Rufaidah went out to the community and tried to solve the social problems that lead to some diseases. According to Qasule (1998), she was both a public health nurse and a social worker. Her assistance and support reached every Muslim in need, including the poor, orphans, and handicapped (Miller, 2007).
Modern studies showed that prayer can be a powerful healer by itself and can also increase the healing power of other medicines (Burns, 2001). The Quran and Hadith (words of Prophet Mohammad) guide Muslims in offering two kinds of prayer for illness; one can be offered to the sick person while he/she is not present. The other type of prayer is offered in the presence of the sick person. Allah, the Exalted, says (in the meaning of): "Oh ye who believe! Seek help with perseverance and prayer: for God is with those who patiently persevere” (Holy Quran, Chapter 11:153). He also said (in the meaning of): "And your Lord says: Pray unto me: and I will hear your prayer” (Holy Quran, Chapter 40:60). These verses along with the verse “We reveal of the Quran what is healing and merciful for the believers” (Holy Quran, Chapter 17:82) indicate that the Holy Quran is not only a source for legislations, but it is also a source for healing. Furthermore, in the Hadith of Buhkari, A'isha reported: "When any person amongst us fell ill, Allah's Messenger (PBUH) used to rub him with his right hand and then say: O Lord of the people, grant him health. Heal him, for Thou art a Great Healer. There is no healer, but with Thy healing Power one is healed and illness is removed” (Burns, 2000). Chapter ‘Al-Fatiha,’ the first chapter in the Holy Quran, is the most common recitation used for healing, and is the recommended incantation if a person does not know the correct supplication for a particular illness. Al-Aswad has narrated that Aisha said that "The Prophet (PBUH) allowed the treatment of poisonous sting with Ruqya".

The practice of regular prayer is the most fundamental practice in Islam. Muslim prayer, which is said five times a day, can be performed almost anywhere, either
individually or in congregation (Syed, 2009). Allah says in the Holy Quran (in the
meaning of): "Pray to me and I will hear your prayer" (Holy Quran, Chapter 40:60).
“This is an extremely noble means because, we directly ask the help from Allah who is
the Healer (al-Shafi) whom we rely on, trust, shelter for recovery, recognizing one’s need
and dependence upon the Sole Sustainer who acknowledges one’s need” (Deuraseh,
2009, p. 3).

Muslims become habituated to using du’a (appealing to Allah and asking him for help) in several events and situations, such as passing an exam, healing the sick and improving their health. However, Burn (2001, p. 1) claimed that Muslims “forget the healing power of prayers in healing.” She claimed that several studies in modern medicine supported the powerful healing effect of prayer in itself and in augmenting the effect of other medicines. For healing, there are two kinds of prayers, one kind (ruqya) can be offered while the sick person is present while du’a can be done whether the sick person is present or not.

To perform ruqya (healing with prayer and reciting several verses from the Quran), the healer puts the right hand at the site of pain or health problem and begins to recite some verses from the Holy Quran or Prophet Mohammad’s words. The origin of these prayers came from the tradition of Prophet Mohammad (PBUH). When he visited a sick person, he used to perform ruqya by reciting the following: “(O Allah! The Lord of the people, the Remover of trouble! (Please) cure (Heal) (this patient), for You are the Healer. None brings about healing but You; a healing that will leave behind no ailment).” In another example, ruqya was used to heal by the Prophet’s companions to cure a man who had been stung by a scorpion (Deuraseh, 2009).
The chapter of the Quran most used for healing is the “Fatihah,” the first chapter in the Holy Quran, and it is the recommended prayer for the person who does not know the specific supplication for a particular illness (Burn, 2001). Although it is not clear how ruqya and du’a work, Syed (2003) argued that prayer and recitation of the Holy Quran lead to physiologic relaxation and that prayers act as a buffer against the adverse effects of stress and anger, perhaps via psycho-neuroimmunologic pathways. Such relaxation may lead to better health.

Burns (2001) suggested that “one should not rule out prayer as at least a supplemental healer.” H. Benson, an associate professor of medicine at the Medical School and director of the Mind/Body Medical Institute, (cited by Cromie, 1997) said: “Anecdotal information about the healing power of faith has existed for centuries. We'll try to put that information on a scientific basis by measuring the possible effects of intercessory prayer. If we can show that prayer helps people who do not even believe in God, that would be revolutionary!” Congruently, Byrd (1988, cited by Cromie, 1997) concluded from his experiment with 393 cardiac patients that prayers promote healing. “Many physicians and patients all over the world believe in the spiritual dimension in healing, such as the power of prayer as an adjunct or a complementary medicine to modern or conventional medicine” (Syed, 2003).

_Spirituality at End of Life and Palliative Care_

Islamic religion has the same origin as Judaism and Christianity. The major tenet of Muslim faith is based on a declaration of monotheism summarized as: “there is no
divinity save God, Muhammad is the messenger of God” (Gatrad, & Shaikh, 2002). This principle is considered the major element that distinguishes Muslims from non-Muslims. It is the core of their daily life and the foundation of their communities (Gatrad, & Shaikh, 2002). These words are whispered in the ears of the newborn as well as the dying. As a part of a comprehensive palliative care, these words are essentially for a dying Muslim (Kassis, 1997).

Historically, most palliative care (about 95%) focused on cancer patients (Tebbit, 2000). According to Oates (2004), spiritual care is an essential component of palliative care. Focusing on cardiac patients, in a study conducted by Bekelman et al. (2009), they used 60 cardiac patients and 30 cancer patients to compare the relative need for palliative care (including symptom burden, psychological wellbeing, and spiritual wellbeing) of cancer and heart disease patients. The Memorial Symptom Assessment Scale-Short Form used to assess symptom burden, the Geriatric Depression Scale-Short Form used to assess depression symptoms, and spiritual wellbeing was assessed using the Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being scale. After adjusting for demographic characteristics, results showed that there were no statistical significance between cancer patients and heart failure patients in the examined domains. For example, cardiac patients and cancer patients had a similar number of physical symptoms (8.6 and 9.1, p=7.9), depression score (3.2 and 3.9, p=0.31), and spiritual well-being (39.0 and 35.9, p=0.31). From these results, Bekelman and colleagues concluded that patients who have heart disease need to receive palliative and spiritual care just as do other cancer patients.
However, there are several treatment options available for cardiac patients; at certain points in time; the goal is shifted to eliminate suffering rather than healing. According to Balarajan & Raleigh (1995), most adult Muslim patients requiring palliative care are cardiovascular patients or experiencing complications of diabetes rather than being oncology patients. Gatrad & Shaikh (2002) called for the need to re-examine the policies and systems in Muslim countries regarding palliative care, not only because of the growing number of elderly Muslims, but also as a result of the breakdown of the extended family.

In Muslim families, elders are perceived with love, loyalty, respect, and honor based on “filial loyalty” (Boule, 1998 as cited by Gatrad, & Shaikh, 2002). However, the new trend is the erosion of the extended family. More young Muslims move away from their families, which increases the demand for palliative care (Gatrad & Shaikh, 2002). Islam is considered a guide for life since it provides much care for human beings up to the last moments of life. Muslims perceive death as a natural part of life, which re-continues in the hereafter. Death is just a ‘path’ or a part of a journey to meet God (Athar, 1993, Athar, 1998). Historically, palliative care has been administered to the sick and dying patients by extended family members at home based on religious guidance. Such care aims to strengthen the relationship of a dying Muslim with God before the meeting on the Day of Judgment. It is noteworthy to emphasize that palliative care in Islam is not just limited to the extended family members; the Muslim community in general can also become involved (Gatrad, & Shaikh, 2002). Furthermore, Gatrad & Shaikh noted that the concept of ‘hospice’ is very limited in the Muslim community, and that there is no direct equivalent word in most Asian and Arab world languages.
During the last moments of life, family members and friends stay at the bedside of the dying person and keep reciting verses from the Holy Quran in the hope to bring peace into the heart of their beloved dying ones. Gatrad, & Shaikh (2002) argue that such praying can alleviate the spiritual pain experienced by the dying Muslim and provide him/her with some psychological comfort.

In spite of all the attention paid by Islam toward palliative care up to the last moments of life, such issues are extremely undervalued in the health care system in most Arab and Islamic countries. However; in the Western countries, there are growing concerns regarding spiritual care, palliative care and caring for terminally ill patients. Most hospitals in many Western countries (in the U.S. more commonly than Britain) assign chaplains or pastors to offer spiritual support for patients; especially those who are terminally ill (Clark, Drain, & Malone, 2003). Usually healthcare providers are too busy to provide such care. It could be argued that the presence of family members beside terminally ill patients or dying ones frees them from this responsibility. But the question still must be raised: should healthcare providers give spiritual care for terminally ill patients in the absence of their family members? Are all family members able to conduct such kinds of care? Do even they themselves need to receive some kind of ‘spiritual’ care and support? Another related question is about the ability and willingness of Muslim healthcare providers to offer spiritual care for dying patients. What is the perception of spiritual care? Is it just praying or a statement about ‘God’s willingness’ and patience mentioned by the provider, or it is broader than this? It may be argued that the shortage faced by the Palestinian health care system, in terms of personnel and resources, may be a key underlying factor for lack of providing spiritual care. However, the spiritual aspect
remains an essential component of the human dimension. There is no excuse to neglect such a crucial aspect. Attending properly to spiritual care may be a method for enhancing the health status of the patients, reducing hospitalization time, minimizing complications, or facilitating a patient’s peaceful death. All of these are core goals and objectives of any healthcare provider.

Although the Islamic rules are considered to be the main determinant for the rituals commonly practiced during the dying process; some cultural issues may be influential and they vary among different countries. Cultural issues should be addressed by the hospitals even within the same Muslim community, unless these issues are in clear contradiction with religious beliefs. According to Gatrad & Shaikh (2002), culture plays an important role in determining the conceptual meaning of illness, health, and death in Muslim communities.

Spirituality and Health Care Professions

With the great number of studies on the role of spiritual care and its effect on health, healthcare providers, especially nurses and physicians, have begun to pay more attention to providing spiritual care to their clients.

Spirituality and Nursing

Nursing is primarily a service to humankind. It incorporates a deeper dimension of loving and caring, which promotes individuals’ wellness. “Nurses who are sensitive to
others are better able to learn about another’s view of the world which, subsequently, increases concern for others’ comfort, recovery, and wellness” (Watson, 2007, p.133).

Nursing deals with clients from a holistic approach. Holism refers to individuals as being made up of the body, mind, and spirit (Narayanasamy, 1996). Holism is a philosophy embraced by nursing and it distinguishes nursing from medical practice. According to the holistic approach, the human being is looked at as a whole that includes both illness and wellness states (Wilt and Smucker, 2001, Timbey, 2009). Therefore, when a nurse deals with patients, she/he performs a complete assessment that includes the areas that the person complains of, as well as other areas and systems that the patient has no complaints about. Dossey, Keegan, Guzzetta, and Kolkmeier (1995) described the holistic nursing approach:

Holistic nursing recognizes that there are two views regarding holism: that holism involves studying and understanding the interrelationships of the biopsychosocial-spiritual dimensions of the person, recognizing that the whole is greater than the sum of its parts; and that holism involves understanding the individual as an integrated whole interacting with and being acted upon by both internal and external environments. Holistic nursing accepts both views, believing that the goals of nursing can be achieved within either framework (p. 7).

According to Sumner (1998), one of the goals of nursing is to “help people reach optimal levels of functioning of mind, body, and spirit, then spirit must be restored to its rightful place” (p. 29). Further, Macrae (1995) stated: “for Nightingale (the founder of modern nursing), spirituality is intrinsic to human nature and is our deepest and most potent source for healing” (p. 8).

Therefore, to provide holistic care, spirituality should be taken into consideration when taking care of clients along with other aspects that include the physical, psychological, emotional, and social dimensions of care (Burkhardt & Nagai-Jacobson,
Jacik (1986) and Montgomery (1991) argue that involving and sharing spiritual resources of the nurse with others is essential.

Since the early 1970s, nurses have focusing much attention on the theories that augment it as an emerging discipline and enhance the practical dimension. The holistic approach, in which the human being is viewed as bio-psychosocial being, was the core of nursing theories. In spite of the fact that several nursing theories acknowledged the spiritual dimension of the human being, this dimension has been underestimated and was not properly included in most health care facilities. Moreover, healthcare providers, including nurses, are not fully involved in providing spiritual care for their clients (Burkhardt, 1989; Oldnall, 1996; Narayanasamy, 1997; Wright, 1998; Brush & Daly, 2000; Treloar, 2000; Stranahan, 2001; Vance, 2001).

Recently, several studies in nursing have begun to show more interest in and concern about spiritual care. While Carson (1989) acknowledged it as a basic human need, Highfield & Cason (1983) perceived it as the inherent need to find satisfactory answers to the ultimate questions concerning the meaning of life, illness, and death. Regardless of the difficulty in arriving at a unified clear definition of spirituality, individual spiritual needs have been acknowledged. The reality of neglecting, or at least underestimating spiritual needs in its theoretical, practical, and educational dimensions can lead to conclude that nursing does not offer care that is truly holistic (Oldnall, 1996). Oldnall suggests several possible explanations for such underestimation. She mentions that this may include a nurse’s embarrassment to address the issue or it could be due to the fact that the spiritual dimension is unquantifiable, which may jeopardize the scientific nature of nursing. Another reason could be that nurses are not able to fully appreciate the
need for spiritual care of their patients. McSherry and Ross (2002) added that another reason for underestimating spiritual care could be due to the dilemma associated with the vague definition of spirituality which plays a major role in the inability to identify and meet patients' spiritual needs and concerns. Meanwhile, it may be argued that the vague nature of the term “spirituality” puts it within the sphere of nursing as an “art” because it depends on the patients’ subjectivity rather than being guided by the theories and educational guidance (Oldnall (1996); this is congruent with Carper’s (1978) definition of spirituality.

The Nurses’ Role in Spiritual Care

The word “nurse” derives from a Greek word that means “nurturing of the human spirit” (Shih, Gau, Mao, Chen, & Lo, 2001). Therefore, the role of providing spiritual care is one of the core roles of nurses. Jacik (1986 as cited in Carson 1989) delineated the features of nurses who include spiritual service as part of their role. Such nurses would be willing to:

1. Be involved in a relationship with others and share with them their individual pain; listen, say little or nothing sometimes, and ask essential questions when required.
2. Be just an escort as it were, sharing the journey of the others. This indicates serious reflection about the concerns of others and being available when needed.
3. "Love the unlovable, the ungrateful, the uncooperative, the aggressive, and the unreasonable" (p. 53).
4. Be part of a relationship with those who suffer from fragility and overburdened by their life complexities. The nurse should feel free to cry with a mourning patient, to commemorate with one who meets success, to share all kinds of feelings and to recognize experiencing of disbelief or confusion as a result of life events.

5. Smooth the progress of others without assuming responsibility for it.

6. Support others in the process of decision-making.

7. Acknowledge that solutions to problems need to be sought out and found by the person involved rather than others.

8. Acknowledge that one is unable to terminate the suffering and emotional pain of others.

9. Accept others as they are, without trying to remodel them.

10. Support others to express their values, goals, and personal views (Carson, 1989, pp. 53–54).

Furthermore, Narayanasamy (1999) argued that from the beginning, nursing has a rich heritage of not only serving patients but also touching the very spirits of those served. Congruently, in a doctoral study that was designated to “examine if the spiritual dimension of the nurse-patient relationship (SDNPR) contributes to patient well-being,” Rieck (2000, p. 11) mentioned that there are four characteristics that the nurse should have. These characteristics are “concern for the patient in time of need, being recognized as a person and feeling accepted competence, and teaching and explaining.” Furthermore, Rieck added that connection, empathy, and trust characteristics were reported by participants as important attributes to patients’ well-being.
Other characteristics for nurses who are able to provide spiritual care are reported in the literature. Goleman (1995) indicates that nurses need to be able to self-motivate, control stress levels, regulate moods, be empathetic, and persistent in goal attainment, including times when they feel frustrated. Carroll (2001) adds that nurses who are able to provide spiritual care need to be able to recognize that spiritual components are embedded in any problem a person encounters, and to be able to provide help and show warmth through unconditional acceptance. They also need to express a genuine desire to understand the feelings and thoughts of their clients, and respect their beliefs. Furthermore, Carroll added that just being available beside the client and trying to help will bring comfort for them. In addition, nurses need to be able to convey to the patients and their families that they are available if they choose to talk. Nurses need to be able to respond to patients as persons, respect their dignity, help them to feel safe in a strange environment, and protect them in their vulnerability during illness (Carroll, 2001).

_Spirituality in Medicine_

Historically, medicine and spirituality were intertwined and strongly tied to each other. Usually, the healers were the same person as the priest or the religious leader and they used to take care of the body and the spirit of the ill persons in order to heal them from their illnesses. The role of the religious leader was entwined with the role of the healer (Greenberg, 2003). With the advanced and sophisticated medical technology of the present era, the tie between spirituality, healing, and medicine loosened, and the role of spirituality in health was almost forgotten (Rosner, 2001; Scheurich, 2003; Neely &
Minford, 2008). Another reason for delinking spirituality and health according to Calderone (2004) were the ontological assumptions that strive to understand human existence and the rise of positivism. Calderone further added that “the empiricism which underlies the contemporary philosophy of science has, until recently, eliminated any possibility for spiritual inflection upon the very black and white world of scientific realism” (Calderone, p. 1). Furthermore, Sheehan (2005) mentioned that some physicians use the disease model rather than the illness model when they deal with their patients. In the disease model, the physician considers the patient’s signs and symptoms, laboratory results, and other data in order to form a diagnosis and to prescribe treatment. This model does not include the patient’s lived experience with the disease process. On the other hand, the illness model considers the spiritual aspects of the sick person by looking at the lived experience of that person through his/her experience during illness, along with the clinical findings in treating the sick person.

Recently, with the proliferating literature which has underscored the impact of spirituality and religion on health, and with the adoption of the holistic approach that takes care of the person as a whole and “not just as a condition or disease,” a renewed interest has been noticed in medical practice to link between health, religion, and spirituality (Neely & Minford, 2008, p. 176). Furthermore, with the advanced medical technology which helps people to live longer, and with the increasing number of chronic diseases, the goal of medicine has shifted to provide relief and comfort rather than cure and treatment. Such a shift in goals and the growing number of studies offering evidence of the beneficial role of provision of spiritual care and its impact on the health and wellbeing of patients can provide a promising opportunity to involve spirituality in health
care as a source of relief and comfort for these patients (Anandarajah, 2008). Greenberg (2003, p. 3) adds that “physicians are becoming much more attuned to helping patients to access spirituality as a resource in both individual and traditionally communal ways.”

In response to this growing body of literature that has provided evidence for the important role of spiritual care in providing relief and comfort, many authors and scientists have begun to call for replacing the biopsychosocial model for health care with biopsychosocial-spiritual model. According to the biopsychosocial-spiritual model, a holistic approach of taking care of the physical, mental, and spiritual components of health should be considered when dealing with patients (Anandarajah, 2008).

The philosophy of holism was reflected in the WHO’s definitions of health. In its old definition, WHO used to define health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Recognizing the important role of spirituality in health, the WHO recently refined its definition of health to become “health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity” (WHO, 1998, p.1). At the same time, the Association of American Medical Colleges (AAMC), the American College of Physicians, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommended including spirituality in medical teaching (Loboprabhu & Lomax, 2010). Furthermore, the American Institute of Medicine listed spiritual well-being as one of six domains of quality supportive care of the dying (Field & Cassel, 1997). In response to these recommendations and the results of several studies on spirituality in health, health educators recognized the role of spiritual care and many medical schools have begun to offer courses or seminars on spirituality. The number of
schools that were including spirituality in their curricula increased from 13 percent in the early 1990s to 75 percent of accredited American medical schools in 2006 (Pulchalski & Larson, 1998 & Pulchalski, 2006).

In spite of the fact that many physicians believe that they should listen to their patients’ spiritual needs and support them, and many believe that religion and spirituality have a generally substantial positive effect on their clients’ health (Koenig, Bearon, Dayringer, 1989; Chibnall, Brooks, 2001; Armbruster, Chibnall, Legett, 2003; Luckhaupt, et al., 2005; Curlin, Sellergren, Lantos, Chin, 2007), the existing literature indicates that many physicians do not provide spiritual support to their clients (Holmes, Rabow, Dibble, 2006). The reasons for not assessing and providing adequate spiritual care by physicians to their clients summarized by Ellis, Vinson, Ewigman (1999) and Koenig (2004) includes physicians being unaware of why they should address spiritual care, their feeling of being uncomfortable when asked to provide spiritual care, not having time to do it, and being concerned about invading the privacy of their clients, since they feel that spirituality is a private matter. In addition, there is a lack of a common language in dealing with spirituality and concerns about ethics and differences in religion and culture.

Spirituality and Health Education

Recently, with the proliferating literature which revealed the impact of spirituality and religion on health and with the adoption of the holistic approach which takes care of the person as a whole, several organizations such as the Association of American Medical
Colleges (AAMC), the American College of Physicians, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommended including spirituality in the education of health care professionals.

*Spirituality and Nursing Education*

In spite of the fact that the nurse’s goal is to provide a holistic care to clients, teaching spiritual care is not adequately addressed by nursing schools. According to Meyer (2002), although nursing students believed that providing spiritual care was an essential part of holistic care, they feel that they were not adequately prepared to provide such care for their clients.

In a study that aimed to explore the extent to which spiritual care was addressed in Canadian nursing schools, Olsen, Paul, Douglass, Clark, Simington, and Goddard (2003) discovered that spirituality was rarely included in nursing curricular objectives. If present, it was found in specific course objectives or taught irregularly by nursing educators who had a specific interest in spirituality and spiritual care. Furthermore, several studies reported that nurses believed that their nursing education did not prepare them to deal with sensitive issues related to spirituality and that their nursing curricula focused more extensively on concrete aspects of care (Sellers & Haag, 1998; Vance, 2001; and Hessig, Arcand, & Frost, 2004). But this is not the case for nursing schools that are affiliated with religion, since the curricula of these schools has incorporated spirituality in most of their courses (Fulton, 1992), and more time was devoted by nursing educators to teaching spiritual care (Peterson, 1997). Fulton
further added that nursing students from religiously-affiliated schools are more able to provide spiritual care for their patients than nursing students from public or secular schools.

Nursing education has a central role in preparing nurses for the challenge of helping patients with their spiritual concerns (Harrison 1993, Narayanasamy 1993, Ross 1996, McSherry & Draper 1997, Bradshaw 1997). Bradshaw (1997) suggested that preparing nurses for how to care is the best alternative way to teach them how to satisfy the spiritual needs of their patients. She emphasized the ethical and moral aspects of caring. “However, it appears that Bradshaw espouses a model that is traditional in nature and this tends to be dismissive of contemporary approaches to spiritual care teaching” (Narayanasamy, 1999). In the meantime, more direct and explicit approaches of teaching spiritual care for nurses were introduced by Narayanasamy (1998), McSherry and Draper (1997) and Ross (1996). McSherry and Draper (1997) identified several internal (political, socioeconomic, managerial or educational) as well as external (social, cultural and religious) factors that may impede the full integration of the spiritual dimensions in nursing curricula. Thus, some kind of changes and modifications should be introduced to the nursing curricula in order to integrate spirituality within the nursing educational programs. As well, Narayanasamy (1993) and Ross (1996) provided research verification suggesting that nursing education scope needs to be more comprehensive in its approach by amalgamating spirituality as a subject into its curriculum. Narayanasamy (1999) suggested that the ASSET model (Actioning Spirituality and Spiritual Care in Education and Training) for nursing is a clear direction for delivering spiritual care education. The model is structured on components of self awareness, spirituality, and the spiritual
dimension of nursing. It builds on the nursing process, including factors such as assessment, planning, implementation and evaluation. A major advantage of this model is that it is flexible, and offers “salient features related teaching and learning spirituality” (Narayanasamy, 1999, p.275).

**Spirituality and Medical Education**

By reviewing the medical history, it was noticed that medicine and religion were closely tied to each other. In fact, priests and other religious men were taking the doctors’ role and they used to take care of the body and the spirit of the ill persons in order to heal them from their illnesses. With the advanced and sophisticated medical technology of the present era, the tie between spirituality, healing, and medicine grew looser and the role of spirituality in health was almost forgotten (Rosner, 2001; Scheurich, 2003; Neely & Minford, 2008). Another reason for delinking spirituality and health according to Calderone (2004) was the ontological assumptions that strive to understand human existence and the rise of positivism. Calderone further added that “the empiricism which underlies the contemporary philosophy of science has, until recently, eliminated any possibility for spiritual inflection upon the very black and white world of scientific realism” (Calderone, p. 1).

Recently, with the proliferating literature that revealed the impact of spirituality and religion on health and with the adoption of the holistic approach, which takes care of the person as a whole and “not just as a condition or disease,” a renewed interest has been noticed in medical practice to link between health, religion, and spirituality (Neely &
Minford, 2008, p. 176). The philosophy of holism was reflected in the WHO’s definitions of health. In its old definition, WHO used to define health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Recognizing the important role of spirituality in health, the WHO recently refined its definition of health to become “health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity” (WHO, 1998, p. 1).

With the abundant research about spirituality in health and the role of spirituality in providing a comprehensive patient care, medical educators became more aware of the importance of including spirituality in medical education (Tang, White, & Gruppen, 2002). Based on that, several medical educators advocated the inclusion of spirituality and spiritual care in medical education, which they considered as an asset and added to the diversity of physicians’ training (Barnard, Dayringer, & Cassel, 1995). Besides that, several authors advocated including spirituality into the curricula of medical education and stressed the importance of teaching spirituality to future physicians (Wear & Castellani, 2000; Blass, 2007).

At the same time, a study by Chibnall & Duckro (2000) that surveyed 137 American medical students revealed that exposing medical students to religion and spirituality during their education predicted a positive attitude of these students toward including spiritual care in their practice in providing optimal and holistic health care. These results suggest that exposing medical students to spiritual issues during their education may result in producing physicians who are more sensitive to their clients’ spiritual needs. In another study, medical students thought that spirituality and religion
are important in their education and they suggested that some lectures or one-to-two-week seminars to be offered to them during their first or second year of medical education (Guck & Kavan, 2006).

Recognizing the importance of integrating spirituality into medical education, the Association of American Medical Colleges (AAMC), the American College of Physicians, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommended including spirituality in medical education (Loboprabhu & Lomax, 2010). Furthermore, the AAMC made several recommendations and guidelines to incorporate spirituality in the curricula of future medical practitioners. For example, the AAMC called for the establishment of learning objectives and methodology for teaching courses on spirituality, cultural issues, and end of life care (Puchalski, 2002) and recommended to include spiritual assessment as a part of their routine when taking patients’ medical history, to assess the role of spirituality in their lives, and to use cases in illustrating and teaching important related concepts (Puchalski, Larson, 1998). On the other hand, the American Institute of Medicine listed spiritual well-being as one of six domains of quality supportive care of the dying (Field & Cassel, 1997), which could apply to other patients such as those diagnosed with heart diseases.

As a result of advocacy and recommendations to include spirituality in medical education, medical schools started to adopt an educational policy of including spirituality into medical education. Dr. Christina Puchalski was one of pioneers who introduced spirituality in medical education. She created a course about spirituality and health in 1992 at the School of Medicine at George Washington University in Washington, D.C. (Booth, 2008). Then the number of medical schools offering course related to spirituality
and health started to grow. According to Pulchalski & Larson (1998), in the early 1990s, only 17 medical schools (13%) out of the 126 accredited schools in the United States were including spirituality in their curricula. The number of the medical schools in the United States that include spirituality in their education had increased to 75% of accredited schools in the early 2000s (Pulchalski, 2006).

In the United Kingdom, the number of medical schools that include spirituality in their curricula is growing. Recently, the number of schools offering spiritual education was about 53% of accredited medical schools in the UK (Neely & Minford, 2008). The courses on spirituality were offered either as mandatory or as elective courses. The majority of medical schools in the United States (75% of schools teaching about spirituality) require that medical students should take at least one course related to spirituality (Booth, 2008).

Studies about Spirituality in Health

Spirituality and spiritual care have been the core of several studies in the past few decades. Some of these studies targeted patients as their participants, while in other studies, nurses were the participants. But what was noticed in the literature is that oncology patients were central in most of these studies. At the same time, it was noticed that spirituality among cardiac patients was not studied as much as in the case of oncology patients.
Clients' Perception of Spirituality and Spiritual Care

An important means of looking at spirituality, spiritual care, and spiritual needs is to investigate the patients’ perception of these topics. Therefore, several studies were conducted to explore patients’ perceptions of spirituality. In a study aimed to describe the phenomenon of spiritual distress, Smucker (1996) asked ten participants to describe their concerns about the meaning of death, life, and some of their beliefs. Results showed that participants perceived spiritual distress as a biphasic process through which they proceeded from distress to change and growth. In another qualitative study that aimed to formulate a grounded theory about spirituality of patients approaching death, Thomas and Retsas (1999) interviewed 19 Australian adult patients who were diagnosed with terminal cancer. Results showed that patients with terminal cancer developed a spiritual concept that helped them to strengthen the way they perceived life and death concepts. The meaning of spirituality was reflected in "transacting self-preservation" (p. 191). This process entailed three phases: taking it all in, getting on with things, and putting it all together. As participants moved through these three phases, they transacted self-preservation by developing deeper levels of understanding of their selves, which in turn promoted their spiritual growth. Furthermore, the study revealed that nurses can help such patients to develop coping strategies that can assist them to engage in the process of self-preservation and therefore help to promote their spiritual growth and awareness. Thomas and Retsas concluded that spiritual support care might simply mean "taking the time to provide physical and psychosocial caring that touches the spirit" (p. 200).

In other research, Taylor (2007) conducted a pilot quantitative study that aimed to
address the following question “what characteristics does a client look for in a nurse before welcoming spiritual care from that nurse?” (p.44). A total of 156 adult patients who were receiving treatment for cancer and 68 family caregivers returned a self-administered questionnaire. The Nurse Requisites Scale was used to assess the characteristics a client would look for in a nurse before welcoming spiritual care from that nurse. Results showed that the following characteristics (ranked from most important to least important according to the mean, noting that the maximum score is 4) are the most important for a client to see in his or her nurse (p. 45):

1. First, show me genuine kindness and respect (M=3.17)
2. Get to know me first (M=2.80)
3. Have had training about providing spiritual care to ill persons (M=2.62)
4. Have had religious training (M=2.36)
5. Have spiritual beliefs similar to mine (M=2.23)
6. Have had personal experiences like I’m having (M=1.98)
7. Be from the same religious background as me (M=1.97).

Nurses’ Perception of Spirituality and Spiritual Care

Another significant means of looking at spirituality, spiritual care, spiritual needs, and appropriate spiritual nursing intervention is to investigate the healthcare providers’ perception of these topics. In a phenomenological study, Deal (2010) explored the lived experience of nurses about giving spiritual care. From the analysis, five themes emerged: spiritual care is patient-centered, spiritual care is an important part of nursing, spiritual
care can be simple to give, spiritual care is not expected but is welcomed by patients, and spiritual care is given by diverse caregivers. Some nurses thought that spiritual care “…is what the patient wants” (p. 858) and therefore, they “would never want to push anyone into a conversation that they are uncomfortable with” (p.858). They further added that usually the patients, not the nurses, lead the journey through giving spiritual care. Although nurses thought that patients were not expecting nurses to offer spiritual care, especially in health care settings that were not affiliated with religious organizations, they thought that patients felt comfortable when nurses offered it.

In a similar study, Kociszewski (2004) conducted a phenomenological study to describe the lived experience of critical care nurses about providing spiritual care to critically ill patients and their families. Results revealed that in spite of the fact that nurses defined spirituality according to their approaches to spiritual care, their responses reflected that they provided spiritual care as part of a holistic approach for their patients, and it was hard to separate from everyday care. Results also showed that these nurses’ experiences about providing spiritual care did not stem from formal education, but rather from professional experience of caring for critically ill patients and their families during the vulnerable time of illness. Also nurses admitted that care for such patients and their families with such experience of vulnerability and experience of spiritual distress provided them (the nurses) with spiritual growth and significant meaning, and this resulted in professional satisfaction.

In another study conducted by Lundmark (2006) to identify factors that influence Swedish oncology nurses’ attitudes toward spiritual care, 93 nurses were approached, and 68 participated in the study. Results revealed that nurses thought that providing a holistic
approach was important, but at the same time, some two-thirds of participants thought that holistic nursing care was not provided in their units. The majority of nurses thought that spiritual care was an important part of holistic care, and about 75% reported that it was provided to their patients in varying degrees. Results also revealed that there were some factors that influenced nurses’ attitudes toward spirituality. These factors related to the religiosity of nurses, including faith in God, belief in life after death, and organized and non-organized religiousness. Furthermore, results showed that there was a connection between positive attitudes of nurses toward spirituality and their practice of providing spiritual care to their patients. An important finding of this study was that the majority of nurses did not receive formal education about spirituality. In spite of that, nurses who received more education about spiritual care believed that they had a better ability to provide such care, which reflects the importance of incorporating spirituality in the curricula of nursing education.

Finally, Leeuwen, Tiesinga, Post, & Jochemsen, (2006) conducted a study aimed at investigating how nurses pay attention to the spirituality of their patients. Nurses and patients from oncology, cardiology, and neurology departments were interviewed in focus groups. Results showed that patients emphasized the presence of professional skills, while nurses questioned their role in providing spiritual care. In spite of that, nurses reported that they had been affected by the conditions of their patients, which had influenced them to pay more attention to their patients’ spiritual needs. Patients noticed that older nurses paid more attention to their spiritual needs, while nurses thought that when they get older, they develop more experience in this area. While patients noticed that religious nurses paid more attention to spiritual care, both patients and nurses agreed
that the patient is the one who should imitate the conversation about spirituality. Furthermore, patients thought that differences in ideology and generation gap were obstacles for communication related to spirituality. On the other hand, nurses thought that lack of time impeded provision of spiritual care. Finally, nurses reported that they lacked educational preparation to provide spiritual care for their clients. They thought that they needed additional training about how to incorporate spiritual care in professional holistic care.

In summary, nurses think that providing spiritual care is an important component of holistic care. In spite of that, there is a lack of providing spiritual care to their patients. It was also noticed that lack of time and previous formal education about spirituality were some of the factors that contributed to inadequate provision of spiritual care. Usually, patients did not expect nurses to provide spiritual care, but they welcomed it when nurses did. In general, older nurses, nurses who had more experience, and religious nurses provided more spiritual care to their patients.

*Studies about Spiritual Care for Cardiac Patients*

Most of the studies addressed spirituality were concerned with oncology and AIDS patients rather than cardiac patients (Kliewer, 2004). Some studies compared the spirituality of patients diagnosed with heart disease with the spirituality of patients diagnosed with several types of cancer. Although 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, and that stress, anger, depression,
and hostility impede the recovery from heart attacks (Harvard Men’s Watch, 2006), only a few studies have explored spirituality among patients with heart failure and other cardiac health problems (Beery, Bass, Fowler, & Allen, 2002).

Murray, Kendall, Boyd, Worth, & Benton (2004) conducted a qualitative study among twenty patients diagnosed with inoperable lung cancer and twenty patients from the New York Heart Association with grade IV heart failure, as a part from a larger study, to gain access to the patients’ personal beliefs and understanding about if they considered their experience with a life-threatening illness a significant spiritual need or not. They also aimed to see how spiritual concerns might vary through the different stages of the disease, besides exploring whether the patients and their caregivers thought that they could be supported in satisfying their spiritual needs or not. The researchers interviewed the patients and their caregivers at intervals of three months for up to one year at home. Results showed that both groups of patients reported spiritual distress. Both groups of patients reported struggle with changes in their self-image and their relationships with others, especially as dependence on others increased. They also reported the need for peace of mind and spiritual wellbeing. Results revealed that spiritual aspects were an important element and the need for spiritual care was not met for either the patients or their caregivers. Patients and the caregivers expressed fear, distress, and uncertainty, although the expression of that was not direct in all cases. There were several questions regarding the possibility and immediacy of death. Patients with heart disease reported more feelings of hopelessness, isolation, and loss of confidence. According to Murray et al. (2004), loss of meaning and purpose in such patients were symptoms of clinical depression and spiritual distress. Cardiac patients also talked more about physical needs
and practical obstacles to maintain their activity of daily living and social life. Patients mostly lost hope; they felt unvalued and that they were just a burden on others. However, religious patients and caregivers expressed receiving comfort from prayers and the support of their churches. Caregivers for these patients reported that they were spiritually challenged and were struggling with their own spiritual needs, since they did not know how to help their beloved ones to overcome their spiritual distress. Participants also reported that healthcare providers provided occasional spiritual care to them but sometimes, they unintentionally caused spiritual distress to them by undermining their sense of self-worth and identity. Finally, Murray et al. reported that participants were reluctant to talk about their spiritual needs, especially at the first interviews, and that encouraging them to talk about this topic needs special communication skills on the part of the interviewers.

In their study in 2001, Westlake and Dracup found that cardiac patients described three processes in order to adjust for chronic heart failure. Such processes included regret regarding previous life style, a search for the meaning of the current experience of the disease, and a search for hope for the future and regaining of optimism. In terms of quality of life of cardiac patients, Beer, Bass, Fowler, and Allen (2002) found that spirituality scores, using the Spiritual Well-being Scale (SWS), predicted about one quarter of the variance in the global quality of life among 58 patients with heart failure. Their study also reflected a distinction between spirituality and religion; existential wellbeing had a slightly stronger relationship with the general quality of life than religious wellbeing.
Searching for differences of spirituality among patients diagnosed with heart failure in terms of the disease stage and gender, Hardin, et al. (2003) conducted their study using a total of 100 patients and found that patients in later stages of chronic heart failure scored significantly lower on the Spiritual Involvement and Beliefs Scale than those in the early stages, regardless of their gender. Those patients at advanced stages were less inclined to use prayer and meditation than patients in earlier stages of the disease. The researchers tried to explain this result and reasoned that patients at the late stages of the disease were more concerned about basic physical needs. They added that these patients, because they lack physical capabilities, might need someone else to pray for them. Finally, the researchers thought that this could be due to the low response rate (29%), and they called for more investigation (Hardin, et al., 2003).

In a different study, Arnold, Herrick, Pankartz, and Muller (2007) investigated the relationship between spiritual wellbeing, emotional distress, and perception of health among 124 patients recovering from myocardial infarction (MI). The results of the study showed a negative correlation between spiritual wellbeing and emotional distress, but a positive relationship correlating spiritual wellbeing with the health perception. Thus, high spiritual wellbeing scores might be associated with improved clinical outcomes.

However, most of the studies indicated a relationship between spirituality and the health status of cardiac patients, there were some studies that revealed contradictory results. Harvard University is famous for conducting studies exploring the relationship between spirituality, religion, and prayer and health, especially for cardiac patients. In 2006, a study called STEP was conducted to examine the effect of prayer in facilitating the recovery from Coronary Artery Bypass Graft (CABG) among 1,800 patients at six
American medical centers. Intercessory prayers were offered for one third of the patients after being told about this, the second third did not receive any prayer and the last third received a prayer after being told that they would receive it. The results showed “no effect of the intercessory prayer on complication-free recovery from CABG, but certainty of receiving intercessory prayer was associated with a higher incidence of complications” (Harvard Men’s Watch, 2006). There was no explanation for such results, but this was attributed to the fact that the prayer was offered by strangers rather than relatives or friends.

Aviles, Whelan, Hernke, Williams, Kenny, O’Fallon, and Kopecky (2001) conducted a study similar to the one by Harvard Men’s Watch (2006). The study aimed to find out the effect of intercessory prayer on the progress of cardiovascular patients. A total of 799 cardiac patients who were admitted to coronary care units were randomized into 2 groups after discharge from these units. Participants in the intercessory group received intercessory prayers, prayer by one or more on behalf of another, at least once a week for 26 weeks. The control group did not receive any prayers. At the end of study, researchers concluded that intercessory prayer did not have a significant effect on the medical outcomes of participants who received such prayers.

In another study, MANTRA II, 748 cardiac patients from nine American medical centers were randomly assigned into four intervention groups before undergoing elective coronary catheterization and angiography with a chance for an artery opening procedure. One group received only standard medical care, the other group was given standard care plus prayer, the third group received the standard care plus music, imagery, and touch (MIT), and the last group received both prayer and MIT therapy. The patients were
tracked for six months after the catheterization. However, the results did not indicate any differences in the risk of major side cardiac events among the groups. The researchers noted that patients who received MIT experienced a clear decrease in anxiety and emotional distress, and they were 65% less likely to die during the subsequent six months. This study indicated the absence of an effect of distant prayer, but did not examine the effect of bedside prayer or prayer by the patient (Harvard Men’s Watch, 2006).

Looking at another aspect, Black, Davis, Heathcott, Mitchell, and Sanderson (2005) examined the relationship between the spirituality of heart failure patients and their compliance with the treatment. They used a convenient sample of male and female cardiac patients older than 21 years who had been diagnosed with heart failure for longer than two months. The researchers used the Spiritual Assessment Scale (SAS) and the Heart Failure Compliance Questionnaire (HFCQR) in their investigation. The results of this study indicated the absence of any relationship between the variables of spirituality and compliance among the heart failure patients.

To examine the relationship between multiple dimensions of spirituality and longevity, Park (2008) conducted a study that included a total of 111 patients with severe congestive heart failure who were assessed twice with a six-month interval. Results showed that participants had increased levels of spiritual struggle, daily spiritual experience, forgiveness, and religious life meaning. Results also reported that participants who perceived that their deaths were approaching had increased levels of spirituality in the areas of forgiveness and perception of a meaningful religious life. In Park’s analysis, he suggested these findings could be related to the fact that people at the end of life feel
“compelled to seek out the positive elements of their spirituality and to let go of the more emotionally upsetting aspects” (p. 10). In addition, Park added that experiencing a decrease in spiritual struggle allows individuals to become more comfortable in acknowledging uncertainty about longevity.

In another study, Whelan-Gales, Griffin, Maloni, & Fitzpatrick (2009) explored spiritual well-being and spiritual practice in elderly patients hospitalized with heart failure. Out of 41 eligible patients (more than 65 years), 24 responded with a response rate of 58.5%. Whelan-Gales et al. used the Spirituality Index of Well-Being (SIWB) to measure spiritual well-being, the Spiritual Practices Checklist (SPC) to identify spiritual practices, the Center for Epidemiologic Studies Depression Scale (CES-D) to measure depressive symptoms. Results showed that the mean total score of the SIWB was 36.33(range from 18 to 58, out of 60). 79.2% of participants were found to have depressive symptoms. 94.7% of those who had depressive symptoms were found to have symptoms of severe depression. Finally, all participants reported that they practiced at least 2 spiritual practices. Exercise, including walking, was reported to be the most frequent practice (91%) followed by recalling positive memories and staying in a quiet place (87%), praying alone (83%), and listening to music and relaxation (79%). Whelan-Gales et al. noticed that when the depression scores increased, the scores of spiritual well-being decreased, which affected negatively the participants’ outlook on life.

Finally, Marcuccio, Lovinga, Bennett, & Hayes, (2003) surveyed 204 women diagnosed with heart diseases to assess women’s attitudes, including psychological well-being and spirituality, toward heart disease and how the disease affected their lives. Results showed that 52% of women were dissatisfied with the care they received and that
the most common reason reported by them was physician-related problems such as poor communication skills and insensitivity. About 37% of participants reported that they could not make changes to their life style while 63% could make only minor changes to their life style after being diagnosed with heart disease. The most reported causes for not being able to adopt changes in lifestyles were related to being unable or unwilling to adopt such changes. Being diagnosed with heart disease had affected the participants’ relationship with family members and friends. 27% reported that their relationship with family members and friends improved and that they were supportive to them while another 27% reported that it had deteriorated. The majority of participants (57%) reported that they had signs and symptoms of anxiety and depression after being diagnosed with heart disease and many women felt that they were socially isolated after the diagnosis. After the diagnosis of heart disease, 40% of participants reported that they had some changes to their spiritual life. Of them, 48% reported improvement in their spiritual lives and that their illness helped them to be more thankful and reflective, while some (6%) reported loss of faith, and about 10% of them could not describe how their spirituality changed. Some of the spiritual changes reported by participants included “putting thing into perspective,” “no longer dwelling on trivial things,” becoming “more aware of their bodies,” and “increasing their sense of vulnerability” (p. 27). Marcuccio et al. concluded that the findings of this study might help in explaining why women with heart disease have poorer medical outcomes than men. Therefore, providing spiritual care to such women might help them to adopt changes in life style and diet that might help them to improve their health outcomes.
Although literature review revealed a few articles about spirituality in Islam (Rasool, Athar, 1993, Ather, 1998, Rasool, 2000, Ather, 2003, and Stacy, 2008), no studies were found to address this topic. In 2007, Musa conducted a doctoral study to explore the spiritual needs and spiritual nursing care offered for the CABG Muslim patients in Jordan. In this study, the patients expressed their belief that nurses were the most appropriate health care providers to offer spiritual assessment and spiritual care for them. Furthermore, more that 50% of the patients perceived that it is very important that the nurses offer spiritual interventions for them.

Barriers and Challenges to Providing Spiritual Care

In spite that nurses and other health care providers strive to provide a holistic care to their patients, providing spiritual care has been neglected or underestimated, although that there are several theories that acknowledged the spiritual dimension of the human being and emphasized its importance (Oldnall, 1996). By consulting the literature, it was found that there are several barriers and challenges that hinder the provision of spiritual care by nurses and other health care providers.

One of these barriers and challenges to providing spiritual care is the ambiguity of the term ‘spirituality’. Sawatzky & Pesut (2005, p. 24) mentioned that “one of the greatest barriers to spiritual nursing care may be a narrow understanding of spirituality that prevents us from hearing the spiritual journeys of our patients.” Oldnall (1996) thinks that nurses were cautious that the unquantifiable nature of spirituality could jeopardize the science of nursing as the profession was trying, few decades ago, to prove the
scientific nature of nursing science which led to ignoring the spiritual part in providing nursing care. At the mean time, it could be argued that the vague nature of the term ‘spirituality’ puts it under the ‘art’ part of the nursing profession because it depends on the patients’ subjectivity rather than being guided by theories and educational guidance. Lemmer (2005) further added that “spiritual needs may often be confused with emotional concerns” (p. 318). Such confusion may hinder the provision of spiritual care by health care providers.

Another reason that may relate to underestimating spiritual care is nurses’ embarrassment to address this topic (Oldnall, 1996). Since the religion and religious practices of patients are considered private matters to that person, there is a strong societal force to avoid discussing this topic when providing care to the clients. Such discussion could be perceived as intrusiveness and violation of patients’ privacy during the vulnerable time of illness (Narayanasamy & Owens, 2001 and Sawatzky, & Pesut, 2005). In fact, a study conducted by Meyer (2002) revealed that students graduated from public nursing schools thought that spirituality was a too private issue to be discussed with patients.

In a different perspective, Baladachinno (2006) argued that the medical model was dominating the nursing assessment of the client’s needs. As a result; only the physical needs, which are determined by clinical features, attract the attention of the healthcare providers while other needs such as spiritual needs are neglected.

In a qualitative study, Dover and Bacon (2001) determined several key elements that are necessary for providing spiritual nursing care for the clients. These elements include: readiness and preparation, recognition of spiritual concerns, experience in
spiritual interventions, and the ability to move the dialogue with the patient into prayer. Therefore, absence of these elements can be considered as a barrier for offering spiritual care. Furthermore, Dover and Bacon (2001) identified several constraints that impeded nurses' ability to offer spiritual care during hospitalization for medical or surgical patients. These constraints included focusing on physical needs as top priority, work and procedures requirements that consumed the nurses' time, and "varying expectations of nurses and healthcare agencies regarding the role of nurses in offering spiritual care for clients" (p.19). In another quantitative study, Bath (1992) explored the challenges that nurses and nursing students faced when providing spiritual care to their patients. Bath found that lack of time, lack of knowledge about spirituality and spiritual care, and uncertainty about their own personal spiritual beliefs were reported as factors that impeded their ability to provide spiritual care.

One of the most barriers to providing spiritual care reported in the literature was lack of time to provide such care (Bath, 1992; Sumner, 1998; Dover and Bacon, 2001; Koenig, 2004; Lemmer, 2005). To provide spiritual care to their patients, health care providers need to build therapeutic relationships with their clients and that the clients trust them. Building such a relationship would require the physical presence of the health care providers with the client for prolonged periods of time and his/her willingness to listen actively to their clients. Such relationship will encourage the clients to share important issues with their nurse or physician. As health care providers do not have such time to spend with their clients, this will hinder the provision of spiritual care (Lemmer, 2005).
Another barrier that was reported in the literature is the lack of experience of nurses and physicians to provide spiritual care. In a phenomenological study conducted by Kociszewski (2004), critical care nurses reported that they were lacking the experience to provide spiritual care and they were unable to handle complex spirituality issues. Furthermore, critical care nurses reported that they were torn between meeting the physical needs of their patients and the spiritual needs of the patients and their families.

Several authors mentioned that educational preparation to provide spiritual care is essential to prepare nurses and other health care providers to provide such care. Therefore, lack of addressing spirituality in curricula of nursing and medical schools leads to poor and improper provision of spiritual care (Ross, 1995; McSherry & Draper, 1998; Greenstreet, 1999; Dover & Bacon, 2001; Koenig, 2004; McSherry, 2006; Ross, 2006; van Leeuwen et al., 2006). Unfortunately, healthcare providers, including nurses, lack the required knowledge and competence for offering spiritual care (Harrison, 1993; Narayanasamy, 1993; Ross, 1995; Fletcher, 2004; Koenig, 2004). Therefore, nursing and medical schools need to address spirituality and spiritual care in their curricula (Lemmer, 2005; Loboprabhu & Lomax, 2010).

In fact, Lemmer (2002) found that 87.4% of nursing programs did not have an agreed upon definition of spirituality and 93.8% of them did not agree about a unified definition of spiritual nursing care. Pulchalski & Larson (1998) mentioned that only 13% accredited medical schools included spirituality in their curricula in the early 90’s, but the number increased to 75% in 2006 (Pulchalski, 2006).

Some of the reasons for not integrating spiritual care in the curricula of health education may include issues related to the complexity of spirituality and the complexity
of defining spirituality and spiritual care in a culture that values materialism and secularism; the limited resources experienced by several nursing programs; and lack of experienced faculty members who would serve as a role model for the students (McSherry & Draper, 1997; Hurley, 1999; Pesut, 2002). The case in Gaza Strip, regarding inadequate inclusion of spirituality in the curricula of nursing schools, is not different from those reported in the literature. In a previous study, Abdul-Aziz (2006) examined the curricula of the three nursing schools (two schools afforded a bachelor degree in nursing and one school offered an associate degree in nursing) that were available in Gaza Strip at that time. The result of that study revealed that spirituality and spiritual care was absent from all courses taught by the three schools. The interview of the researcher with the faculty members of the three schools revealed that even the few pages that were available in some textbooks about spirituality were avoided by nursing teachers.

Underestimation of spiritual care is not limited only to the curricula, but also it extends to the textbooks. In their revision to the leading textbooks; Lewis, Heitkemper, Dirksen, O’Brien, and Bucher (2007) found that spirituality was touched only in one page out of a 1,884-page medical/ surgical nursing textbook, and that page was primarily associated with complementary and end-of-life care. The text book of the medical-surgical nursing written by Smeltzer, Bare, Hinkle, and Cheever (2007) tackled the topic of spirituality and spiritual care only in five pages. Other few chapters (i.e. leukemia, surgery, and end of life) included spiritual care in inconsistent manners (Lewis, et al., 2007).
Inadequate provision or underestimation of spiritual care is not unique to nurses. Physicians also share nurses this phenomenon and they share most of the barriers and challenges reported in nursing literature that deter the provision of spiritual care. Koenig (2004, p. 1197) summarized the reasons why physicians do not regularly address spiritual issues of their clients as follow: “they are unaware of the reasons, time and energy should be expended to address spiritual issues; they do not feel comfortable doing it; they do not feel they have the time; and they are concerned about overstepping boundaries.”

Finally, McSherry (2006) divided barriers to providing spiritual care into intrinsic and extrinsic barriers. Intrinsic barriers are those barriers within the person. In this case, intrinsic barriers could be related to nurses and other health care providers or to the patient him/herself. McSherry listed many examples for intrinsic barriers to providing spiritual care. The list included: inability to communicate through illness or loss of senses, ambiguity about spirituality, lack of knowledge in the area of spirituality, patient not aware of the concept of spiritual need, the issue about spirituality is that it is a sensitive area (too personal for health care providers to address), our own personal believes and values, the topic is emotionally demanding and fear-provoking, and prejudices about certain group of patients affiliated with certain religions or diagnosed with certain diseases such as AIDS. She further mentioned that the topic of spirituality is perceived by society as too private to talk about that it seems “that in today’s society individuals feel more comfortable talking about sexuality and elimination than about spiritual matters” (p.128). On the other hand, extrinsic barriers are those barriers that are external to the individual (patient or care giver) and impede the provision of spiritual care. The list of McSherry’s extrinsic barriers included: organizational and management-
related barriers, environmental distractions resulting in loss of privacy, shortages of staff, lack of time to provide spiritual care, lack of educational preparation, reduced patients’ length of stay in hospital, provision of spiritual care is not directly relevant to area of practice, and prevailing opinions within society.

On the other hand, Narayanasamy & Owens (2001) interviewed 115 nurses to explore factors that promote the provision of spiritual needs. The results of their study revealed that nurses became aware of their clients’ spiritual needs when they recognized the patients’ religious background. When nurses and patients shared the same religious and spiritual background, they are encouraged to have a closer relationship with their clients which acted to prompt nurses to respond to the spiritual needs of these clients. Furthermore, nurses involved in this study reported that when the patients initiate a conversation that reflects the patients’ need for spiritual care, usually they are encouraged to respond to those needs. Another factor that was reported as a stimulus to respond to patients’ spiritual needs was the diagnosis of these patients. Usually, when patients are diagnosed with cancer or other terminal illness, nurses are stimulated to meet these patients’ spiritual needs.

With the existence of many barriers to providing spiritual care, it will be important to health care policy makers to work on eliminating these barriers. Therefore, careful assessment of barriers to providing spiritual care will help in introducing this topic into agenda settings. Pushing a certain issue into the agenda setting is the first step in the policy process which will proceed into taking actions to resolve this issue (Gupta, 2001).
Summary

Heart disease is one of the most common diseases in Gaza Strip and it is the most common cause of death. Most of heart diseases have no cure. There are several means of supportive treatment methods for chronic heart diseases. The cost of treatment is usually expensive. In many cases, some treatment options are not available in Gaza Strip which necessitates referring these patients to be treated in neighboring countries. Besides the use of conventional treatment methods, there are several studies that revealed the benefits of providing spiritual care to these patients as it reduces stress and improving physical and mental health and improving quality of life. In spite of that, a few number of studies revealed contradicting results.

The term ‘spirituality’ is vague in nature and it is hard to find a common definition for it, which alter the provision of spiritual care by health care providers. Most of the patients thought that providing spiritual care is important, thought they think that it is a private matter and when it happens, patients should initiate the talk about this topic. Although most of health care providers consider spiritual care as an important part of the holistic care they provide, some of them do not include it in their care. Several barriers to provision of spiritual care were reported in the literature. Some of these barriers included the vagueness of spirituality, lack of time, lack of education, lack of experience, and some health care providers considered it as a private matter. Furthermore, many studies reported that most of the health education programs, including health education program in Gaza Strip, do not cover the topic of spirituality in their curricula. Spirituality was one of the major concerns in almost all religions, including the
established religions: Judaism, Christianity, and Islam. It was used as a major component in providing care to sick people. The most common means of spiritual care in Islam are prayers and ruqia. Most of the Muslim people believe in the power of prayer to help them to cure and improve their health conditions. In spite of the abundant literature about spirituality in health care, it was noticed that most of these studies were conducted in Western Countries which had a majority of Christian population. Only few studies were conducted in Muslim countries about this topic. Another general notice was that the majority of studies about this topic were about patients who were diagnosed with cancer and AIDS. Not as much studies involved studying spirituality for patients diagnosed with heart disease. Therefore, it is hoped that this study will contribute to the body of literature as it is concerned about spirituality for patients living in Gaza Strip, who are mainly Muslims, diagnosed with heart disease.
CHAPTER III
METHODOLOGY

The purpose of this study was four-fold: (1) to assess if spiritual care was provided for the cardiac patients admitted to CCUs in Gaza Strip hospitals; (2) to investigate who should provide spiritual care for those patients admitted to CCUs in Gaza Strip hospitals; (3) to discover the administrative/organizational barriers that impeded the provision of spiritual care to the cardiac patients admitted to CCUs in Gaza Strip hospitals; and (4) to explore what needs to be done to overcome these barriers.

An exploratory triangulated design was chosen to achieve this purpose. This chapter discusses in detail the description and explanation of the design, sampling, setting, instrumentation, data collection, validity and reliability of the instrument, ethical considerations, strategies for data analysis, and the study limitations.

Study Design

The design selected for this study was a cross-sectional, exploratory, triangulated design using an interview-based questionnaire for the quantitative part and semi-structured interview for the qualitative part. This design helped in describing the study variables at a certain, fixed point of time. The advantages of using a cross-sectional design are that it is characterized by being practical, simple, not costly, and easy to use.
(Polit and Beck, 2004, Neuman, 2006). However, this design still has some disadvantages. The data are collected at fixed points of time; thus the results may be vague or misleading. An additional weakness of this design is the inability to infer changes over time (Polit and Beck, 2008). LoBiondo-Wood and Haber (2006) argued that the ability of the researcher to “establish an in-depth development of the phenomena being studied” will be limited by using this design (p. 246). On the other hand, the advantages of using triangulation methods and methodologies in the research have been acknowledged (Babbie, 2001; Neuman, 2006). The use of both quantitative and qualitative approaches not only overcome the disadvantages of each approach, but also strengthens the design and the results of the research (Carr, 1994; Patton, 2002; Punch, 2005).

Participants and Sampling

The target population of this study included all adult cardiac Muslim patients who are admitted to cardiac care units available at any hospital in Gaza Strip. Gaza Strip has 27 hospitals; only 3 of them include exclusive cardiac care units, while the other hospitals admit cardiac patients to intensive care units or to general medical departments. In spite of the fact that the major health care services offered in these departments are medical cardiac care; there is also a surgical cardiac care unit at Shifa Hospital in Gaza city. Besides that, there is a cardiac catheterization center at the European Gaza Hospital (EGH) in the southern part of Gaza Strip in addition to another private center in Gaza city. Any patient under the age of 18 or non-Muslim was not included in this study. This
was because Muslims formed about 99.83% of Gaza Strip’s residents in the year of 1997, according to the Palestinian Bureau of statistics (1997). Usually Christian clients seek health care and medical services in private or Christian health care institutes rather than the governmental centers. Hospitalized cardiac patients who had passed the severe stage of their illness and seemed to be in stable condition were included in the study. Usually, patients in the intermediary units were selected to participate in this study; they are assumed to be more physically and emotionally stable to be assessed for receiving spiritual care. Patients whose conditions were not stable were excluded from the study, since the administration of the questionnaire might cause them some stress which could negatively affect their health status.

Unfortunately, the report of the Ministry of Health, PHIC (2011) showed that there are no available statistics about the number of cardiac patients in Gaza Strip. However, the statistics of the Ministry of Health showed that Shifa Hospital's Coronary Care Unit (CCU) admitted 1952 cases in 2009, Shuhada' Al-Aqsa hospital admitted 568 cases, while Nasser Hospital admitted 1,429 cases. Consequently, the total population of cardiac patients admitted to these hospitals in 2009 was approximately 3,949 admissions (Ministry of Health, 2010). This number did not reflect the actual number of cardiac patients admitted to the coronary care units, as some patients might have repeated numbers of admissions. Unfortunately, there were no available statistics about the actual number of patients admitted to the other hospitals.

Because there were no accurate statistics available for the total number of cardiac patients living in Gaza Strip, and after consulting with the chairman of the dissertation committee, data were collected using a convenience sample that consisted of 279 cardiac
patient participants. According to Creative Research System (2009) and other websites, 384 cases are enough to represent an infinitely large population. Participants were accessed at the hospitals that offer cardiac care in Gaza Strip. To ensure a more representative sample, the selection was made from the three hospitals distributed geographically among Gaza Strip provinces (governorates).

Furthermore, a census sample will be used to approach all medical directors for CCUs, a senior cardiologist from each hospital, head nurses of cardiac care units, and nursing directors of the three hospital that have CCUs to collect data for the qualitative part of the study. The total number for this part of the study was twelve participants.

*Inclusion Criteria*

Cardiac patients who were eligible to participate in this study had to satisfy the following criteria:

1. Adults (over the age of 18 years),
2. Muslims,
3. Suffering from heart disease,
4. Patient admitted to a cardiac care unit in Gaza Strip for at least 48 hours. This period of time is essential to consider the patient as an in-patient (Timby, 2009). Spending 48 hours in the unit means that the client had enough opportunities for communication with nurses and other healthcare providers,
received the immediate and prompt care, and usually controlled any acute pain or existing needs upon arrival to the hospital,

5. Patient was in a stable condition and had the physical ability to comfortably endure the interview, and

6. Patient was mentally capable to answer the questionnaire. This means that s/he was conscious, alert, aware and oriented, able to understand and communicate in Arabic, had no diminished cognitive or sensory abilities, and free from severe pain. To ensure that the participant was conscious and alert (mentally capable), data collectors had to review the medicals charts of the patients to assess their condition, read the nursing notes, and determine if any medication was given to the patients that might affect a participant’s potential awareness and alertness. The data collectors had to contact the assigned nurse who cared for each particular patient and ask about the client’s mental status. In addition, the data collector had to conduct his/her own assessment to detect the participant’s awareness and responsiveness to his/her experience (Malasons, Barkanskas, & Stoltenberg, 1990). The patient’s consciousness can be defined as the individual's awareness of the stimuli from his/her environment and within him/herself, while the participant's orientation can be determined through the patient’s awareness of the persons, places, and time (Malasons, Barkanskas, & Stoltenberg, 1990). In order to assess the pain level, potential participants were directly asked about the level of their pain that they experienced prior to data collection to ensure that they were free
from severe pain that might interfere with their ability to answer the questionnaire.

Thus, non-Muslim patients, patients under the age of 18, mentally disabled, patients who were admitted for less than 48 hours, and patients whose condition was not deemed stable were excluded from the sample. As mentioned, patients whose conditions were not stable were excluded from the study as the administration of the questionnaire might cause them some stress which could negatively affect their health.

Data Collection

Data were collected by the principal researcher and another four trained data collectors. Primarily, data collectors were research assistants who had a degree in nursing and had a previous experience in data collection and participant interviewing. Nurses who work at hospitals were not selected in order to avoid bias during data collection. Furthermore, data collectors were trained by the principal researcher to conduct the interviews under the same standards to ensure reliability and minimize bias. Training for data collectors was carried out in three sessions and it focused on the nature of the research, interviewing methods and skills, communication skills, and steps to ensure meeting of inclusion criteria as well as objectivity and avoiding subjectivity in data collection. One session included simulation and practice. For the qualitative data collection, it was collected by the principal researcher during private meetings with the participants at a time and place convenient to them.
The cardiac patient participants were interviewed privately at their bedside, where they receive health care services. Initially, each potential participant was approached by the data collector and was asked to participate in the study and if s/he agreed, the patient’s consent was obtained to review his/her medical records. Then, the data collector had to review these medical records to have an idea about the health status and the diagnosis of the patient. Then the nurses at the unit were contacted to ensure the eligibility of the patient to be included in this study. If the patient was eligible to participate in the study, the data collector had to explain the content of the cover letter and obtained the participant's consent to participate in the study before starting data collection. The data collector would explain to potential participants the purpose and the significance of the study, general information about the questionnaire, give assurance for anonymity and confidentiality, and explain the patient’s right to refuse or withdraw from the study or not to answer any question. Before conducting the interview, participants were asked to sign a consent form (Appendix A). In case the participant was illiterate, the interviewer had to read the consent form to the participant and sought his/her verbal consent. Interview time averaged about 25 minutes.

Because of the nature of the illness, age, and variant levels of literacy of the participants, which could interfere with their capability to deal with a self-administered questionnaire, the questionnaire was filled in by the data collectors. Despite the fact that the total overall percentage of literacy among Gaza Strip inhabitants in 2008 was 94.4%, it was circa 77.4% in the age bracket 45-54 years old. The last available statistics of literacy among people over the age of 55 years date back to 2002. The illiteracy rate for females between the age of 55 and 64 years was 63.5%, 93.6% for those who were more
than 65 years old. For males, the illiteracy rate for males aged 55-64 was 13.2%, and 59.2% for those 65 years and older (PCBS, 2009a). The statistics revealed a considerable difference between the literacy among males in the age bracket 45-54 years old (90.3%) and females (65.0%) from the same age bracket (PCBS, 2009a). Because of the variation in levels of literacy and level of education among the different age groups of the participants, an interview method was used in data collection to ensure minimizing bias that could derive from different levels of literacy. Furthermore, the availability of the interviewer helped to answer any inquiry by participants if they needed any clarifications about any item in the written questionnaire.

For the qualitative component, participants were interviewed privately by the principal researcher. Before engaging in the interview, the researcher explained the purpose of the study to the participants and they were asked to sign a consent form (Appendix B) to participate in the study.

Settings

This study was conducted at the major three hospitals in Gaza Strip that provide cardiac care. These hospitals are located geographically to cover the five governorates of Gaza Strip. These hospitals differ in size and capacity since they were designed according to the size of the population targeted to be served. These hospitals were selected from the 27 hospitals in Gaza Strip, because they were the only hospitals that had cardiac care units. Other hospitals were either small hospitals or specialized in certain areas of health care such as pediatrics, mental illness, or ophthalmology. The total number of beds
Table 3-1: Table for the Capacity of Each Hospital

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shifa Hospital</td>
<td>30</td>
</tr>
<tr>
<td>GEH</td>
<td>15</td>
</tr>
<tr>
<td>Nasser</td>
<td>10</td>
</tr>
<tr>
<td>Shuhada Al-Aqsa</td>
<td>5</td>
</tr>
</tbody>
</table>

designated for cardiac care was about 60 beds in the four hospitals (Table 3-1) (Ministry of Health, 2006).

The major health care service offered in these units was medical cardiac care, while surgical cardiac care was only provided at EGH which offers only cardiac catheterization on the basis of day care. Cardiac patients requiring surgical operations were referred for treatment in the neighboring countries.

Instrument

According to Neuman (2006), there are two methods to have a valid and reliable instrument for the research. The first method is to develop a new instrument and test it for validity and reliability. The other approach is to adopt an existing instrument either as it is or with some modification. In this study, the second approach was followed. A previously developed instrument crafted by Musa (2007) was used in this study to collect quantitative data from cardiac patients.
The Instrument (Appendix C for English version and Appendix D for the Arabic version) used to collect quantitative data from cardiac patients in this study has two parts; a demographic sheet and the Spiritual Care Rating Scale (SCRS)-domain frequency. At the end of the instrument, there is an open question for the participants if they wish to add any comments. The initial instrument was, as mentioned, developed by Musa (2007). Several modifications were undertaken in the demographic section to render the instrument suitable to be administered for the purpose of this study. Dr. Musa was contacted and his permission was obtained to use the instrument in this study (Appendix E).

*Part I of the Instrument: Demographic Data and General Information*

The first part of the instrument consisted of nine items (Appendix C, part I). The items covered the demographic data (age, gender, marital status, education, and employment) and other health-related data (such as any history of major chronic diseases or surgical operations, for how long a participant was diagnosed with a cardiac disease, and importance of his/her faith).

*Part II of the Instrument: the Spiritual Care Rating Scale (SCRS)*

The SCRS measured participants’ perceptions regarding the frequency of provision to them of spiritual care 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 (Musa, 2007).

This part of the instrument (Appendix C, part II) measured frequency of spiritual care offered by healthcare providers to cardiac patients admitted to CCUs in Gaza Strip. 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 = do not know).

The SRCS was divided by Musa into two major subscales: the Spiritual Care Assessment Rating Scale, Domain Frequency (SCARS-F) and the Spiritual Care Intervention Rating Scale, Domain Frequency (SCIRS-F) (Musa, 2007).

The Spiritual Care Assessment Rating Scale, Domain Frequency (SCARS-F), which contained 18 items (items 1-18), asked about the frequency of spiritual assessment carried by the healthcare providers. These 18 items were ordered to cover nine major themes; spiritual/religious beliefs, relationship to God/Allah and others, meaning and purpose of life, hope and strength resources, exchanging love, illness experience, forgiveness, and selection of proper time (Musa, 2007).

The Spiritual Care Intervention Rating Scale, Domain Frequency (SCIRS-F), which contained 21 items (19-39), asked cardiac patient participants about the frequency of spiritual care interventions provided by healthcare providers to them. These items were structured around sixteen major themes associated with spiritual care implementation. These themes included active listening, facilitating practicing religion, praying with or to the patients, scripture reading, meditation, staying with the patient, holding the patient’s hand, arranging a visit by an Imam (Muslim clergy), facilitating visits by family members
and close friends, respect, comforting and reassuring the patient, sustaining hope, meaning and purpose, laughter and humor, music therapy, and reflecting kindness (Musa, 2007).

The second section of this questionnaire asked the participants to identify the most appropriate person whom they believed could provide spiritual care for them during the time of hospitalization. The last part of the instrument (Appendix C, part 4) offered a chance to participants to share more information by answering an open-ended question about any additional information they wanted to express.

*The Semi-Structured Interview for Qualitative Data Collection*

This part of the instrument was designed to offer a qualitative investigation of the perception of head nurses of the cardiac care units, nursing managers, medical directors, and a senior cardiologist from each hospital with a CCU about: (1) who should offer the spiritual care to cardiac patients, (2) the organizational and administrative barriers and challenges that interfered with the provision of spiritual care to cardiac patients, and (3) the suggested solutions to overcome these barriers. To collect data related to answering these points, several questions were developed by the researcher, based upon her review of relevant literature, to answer related research questions. In addition, there was a front sheet that was designed to collect some demographic data about the healthcare providers participating. The demographic sheet and the list of the questions are presented in Appendix F.
The approach for collecting qualitative data was through a semi-structured interview. The semi-structured interview offers a chance to participants to talk about their experience and perception about spiritual health care and allows them “to tell their stories in the manner they chose” (Green, McSweeney, Ainley, Bryant, 2009, p. 50). In this approach, the interviewer asked some predetermined questions and probed and encouraged participants when necessary to talk in greater depth about their responses (Holstein & Gubrium, 1997 and Patton, 2002). In addition, the use of the semi-structured approach generates “novel insights for the researcher” and enables the investigator to “maintain control of the interview” and manipulate the original research questions (Willig, 2001, p. 22).

**Validity of the Questionnaire**

The instrument used to collect data related to the frequency of providing spiritual care to cardiac patients was developed and tested for validity and reliability by Musa (2007). Musa used factor analysis to test both the content and construct validity of the instrument. Evidence of the content validity for the SCARS and SCI RS was “addressed based on extensive literature research, the judgment of the constructor (face validity), the judgment of the expert panel (content expert), and the feedback and findings of pretest” (Musa, 2007, p. 170). For addressing the content and construct validity, a person’s correlation factors and exploratory factor analysis with Direct Oblimin rotation have been conducted for all the remaining scales (Musa, 2007).
Reliability of the Questionnaire

Generally, reliability of the instrument is defined as “the consistency of a measure obtained in the use of a particular instrument” (Burns & Grove, 2005, p. 374). In particular, internal consistency reliability refers to testing the homogeneity of the instrument’s items. It is “the consistency of performance of one group of individuals across the items on a single measure” (Waltz et al., 2005, p. 140). It is mostly used to test the reliability of instruments measuring the cognitive characteristics (Waltz et al., 2005). Thus it is very helpful with the instruments dealing with psychosocial issues (Burns & Grove, 2005). In his study, Musa (2007) used the internal consistency reliability methods as the basic approach to detect the reliability of his instrument. The statistical procedure of Cronbach’s alpha coefficient, which was used to detect reliability, revealed a relatively strong relationship (> 0.70) between the measured items and the scale (Musa, 2007). Burns and Groves (2005) argued that the acceptable alpha coefficient value for the well-developed psychosocial instrument is 0.80, but for newly developed instruments, 0.70 was acceptable.

Definitions of Study Constructs

For the purpose of this study, the following definitions were used as operational definitions for the included variables:
Operational Definitions

➤ Spiritual care was defined as “the health-promoting attendance to responses to stresses that affect the spiritual perspective of an individual or a group” (Taylor, Amenta, & Highfield, 1995, p. 31).

➤ Hospitalized cardiac patients: patients who were diagnosed with a heart disease and had spent at least 48 hours as in-patient in a cardiac care unit.

➤ Critical cardiac unit (CCU): any unit in any hospital in Gaza Strip which is designed to serve patients diagnosed with heart diseases.

➤ Spiritual care: is “the activities and ways of being that bring spiritual quality of life, well-being, and function” (Taylor 2002, p. 24).

➤ Spiritual need(s): are “any factors necessary to establish and maintain a person’s dynamic personal relationship with God, as defined by the individual” (Stoll, 1979, as cited by Stranahan, 2001, p. 93).

➤ Healthcare provider: any member of the health team involved in the care of cardiac patients such as nurses and doctors.

Data Analysis

The Statistical Package of Social Science (SPSS), version 16, was used to compute and analyze the quantitative data of this study. All responses provided by participants were entered into a personal computer that was assigned a password to ensure that it would be used only by the researcher.
The researcher ensured the accuracy of the entered data by double checking of 20 completed questionnaires, which were selected randomly, and compared the data entered into the computer with the original data. Through running frequencies for all variables of the study, the researcher checked if all the data fell within the accurate ranges for each item and checked for missing data. Results revealed that all data fell within the range of each item and there were no missing data. The absence of missing data is related to the fact that by the end of each interview, each data collector reviewed the questionnaire and made sure that all items were answered, especially that all cardiac participants were willing to provide answers to all items in the questionnaire.

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.

For the qualitative part of this study, the data collected from healthcare providers which related to answering the questions pertaining to exploring the barriers to providing spiritual care and what can be done to overcome these barriers, were analyzed through careful reading of the responses provided by the head nurses, nurse managers, medical directors and senior cardiologists. Data analysis included identifying, coding, and then categorizing the patterns found in data (Bryne, 2001). For this part of the study, the researcher used thematic analysis. Thematic analysis is considered a way of examining data and a process for coding qualitative information (Bryne, 2001). Throughout data coding, the researcher identified and categorized related information; then a label was chosen for each category. In addition, the researcher observed how frequently these codes and categories appeared in the data base to establish the patterns of these categories.
Finally, the researcher identified the major themes and subthemes that emerged from the data. Several quotes from the healthcare providers’ responses were used when appropriate.

**Ethical Considerations**

Prior to conducting this study, the proposal for the study and all relevant materials were submitted to the Internal Review Board (IRB) at The University of Akron and their approval was obtained to conduct the study (Appendix G). At the same, the Palestinian Ministry of Health in Gaza Strip was contacted and their approval for conducting this study was secured (Appendix H).

Prior to participating in the study, the researcher sought and obtained written consent from cardiac patients and healthcare provider participants (Appendix A and B) to participate in this study. In cases where the participant was illiterate, a verbal consent was obtained from the participant and the researcher or the data collector read the consent form for the participant; then, if the participant agreed to participate, the researcher or the data collector continued with the process of data collection. After obtaining the consent of the participant, the researcher or the data collector explained the process to him/her, explained that participation is voluntary and that they could refuse to participate, to not answer all or some questions, or to withdraw from the study at any time. The researcher assured cardiac patients participants that if they would refuse to participate in the study, they would not be penalized nor would their care be affected. Both groups of participants were also assured that the information they shared with the researcher would be kept
confidential and that their names would not be included in any document or in any report, and the data would be reported as a whole without mentioning the names of the participants. Participants were also assured that there would be no direct physical, economic or psychological risks for participation in the study. However, since some participants among the cardiac patients group might be liable to suffer psychological stress while recalling some issues regarding their relation with God, the researcher offered her willingness to refer these participants to proper psychological counseling that is offered cost-free and to call for urgent psychological support if needed. Fortunately, during the data collection process, none of the patients experienced any psychological problem while answering the questionnaire. Completed data sheets were kept in a safe place at the researcher’s home and were then entered into a computerized data file in a personal computer. The computer was assigned a secured password that allowed only the researcher to access the data.

Expected Limitations of the Study

Regardless of the thoroughness of any research study, it may have some limitations. One of the major expected limitations of this study was using a convenient sample rather than the randomized one. Convenient sample, as kind of non-randomized samples, does not represent the population (Neuman, 2006). Thus, generalizability of the study results can be questioned. Another expected limitation was the inability of some of the cardiac patient participants to understand and respond to the questions because of their health and educational status. Most of cardiac patients in Gaza Strip can have a
limited literacy because of their age. The interview was expected to provoke or cause possible negative feelings or induce stress for some cardiac patients. In this case, the interviewer planned to give a break to allow the patient to calm down. If the patient should decide to postpone or terminate the interview, his /her wish would be respected. During the actual data collection, such event was not encountered by the principal researcher or any of the data collectors. Another expected limitation to this study was related to the lack of statistics about the total number of cardiac patients in Gaza Strip, a factor which could interfere with including an accurate and representative sample size. Also, the researcher expected possible inadequate cooperation coming from the Ministry of Health employees when it came to gaining access to some data. In fact, during the actual data collection, the researcher did not encounter any instance of such non-cooperation. On the contrary, Ministry of Health staff was very cooperative during the data collection process.

Summary

A cross-sectional design was used for this study. Both quantitative and qualitative approaches were used for data collection. All patients diagnosed with heart disease who were admitted to one of the cardiac care units in Gaza Strip hospitals during the time of data collection were invited to participate in this study. An instrument that was developed by Musa (2007) was used to collect quantitative data related to answering research questions number one and two. The instrument was valid and reliable. A semi-structured interview approach was used to collect qualitative data from healthcare providers. After
getting the approval from the IRB at The University of Akron and the approval of the Ministry of Health in Gaza, participants were interviewed by the principal researcher and several data collectors. Each participant was asked to sign a consent paper to participate in this study.

After the data were collected, quantitative data were entered into the SPSS program and descriptive statistics were used to describe some variables of the study. After reading carefully the quantitative data, several themes were extracted to answer research questions Nos. three and four.
CHAPTER IV
RESEARCH FINDINGS AND DISCUSSION

This chapter covers the results of data analysis performed to answer the four research questions regarding hospitalized cardiac patients’ perceptions about the frequency of providing spiritual care, the perception of cardiac patients and healthcare providers about who should provide spiritual care to cardiac patients, exploring barriers to providing spiritual care, and possible means to overcome these barriers. A quantitative approach was used to analyze data related to hospitalized cardiac patients’ perceptions regarding the frequency of providing spiritual care and who should provide spiritual care. Results of this study were presented in tables and were discussed within the light of the relevant literature. A qualitative approach was used to analyze data related to barriers to providing spiritual care to hospitalized cardiac patients and possible means to overcome these barriers, and results were related to the relevant literature.

Description of the Sample

This study targeted two groups of participants; cardiac patients who were admitted to cardiac care units (CCUs) available at any hospital in Gaza Strip and healthcare providers who provide care for these patients.
Description of the Cardiac Patients’ Variables

The sample frame for cardiac patients included all adult patients who were diagnosed with a heart disease and admitted to one of the CCUs available in Gaza Strip and had spent at least 48 hours as in-patient in a cardiac care unit. 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, because he experienced some tiredness during data collection, and consequently the data collector decided not to continue with the interview. The total number of cardiac patients who answered the questionnaire was 279 out of 281, with a response rate of 99.29%. This high response rate could be related to the fact that the people of Gaza Strip are relatively cooperative and because participants were approached directly by the principal researcher and the data collector. Such an approach encouraged participants to participate in the study and gave them a chance to ask about any item of the questionnaire that could be unclear. According to Babbie (2001), an interview survey has the advantage of a high response rate. He considered a response rate of 80-85% of interview survey as a “completion rate” (p. 258). Another advantage for interview survey according to Babbie is decreasing the numbers of “do not know” and “no answers” when responding to the questionnaire items (p. 258).
Demographic Variables

Demographic variables related to cardiac care participants included the following: age, gender, level of education, working conditions, hospital of admission, whether participant lives alone, the length of time being diagnosed with a heart disease, if the participant was diagnosed with a chronic health condition, and how important their faith was to them.

Age

The age of the cardiac patient participants in this study (table 4-1) 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. The difference between the two means was found to be significant (t =0.001). This is a normal finding, as the literature reports that male patients are subject to heart disease at a younger age than female patients (Smeltzer et al., 2008).

Table 4-1: Age of Participants who Have Cardiac Diseases.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Participants</td>
<td>279</td>
<td>24</td>
<td>93</td>
<td>59.08</td>
<td>12.865</td>
</tr>
<tr>
<td>Male patients</td>
<td>164</td>
<td>25</td>
<td>93</td>
<td>56.99</td>
<td>12.215</td>
</tr>
<tr>
<td>Female patients</td>
<td>115</td>
<td>24</td>
<td>88</td>
<td>62.06</td>
<td>13.229</td>
</tr>
</tbody>
</table>
Gender

The sample of cardiac patient participants consisted of 279 participants. There were 164 male participants (58.78%), while the number of female patients was 115 participants (41.22%). These findings are in keeping with the literature, since it is known that heart disease is more common among males than females (Smeltzer et al., 2008).

Level of Education

Table 4-2 describes the level of education for the entire cohort of cardiac patient participants and compares the level of education between male and female participants. Only 72 participants (25.8%, 16 male and 56 females) had no formal education, while the rest had received some education.

Table 4-2: Educational Level of Cardiac Patient Participants

<table>
<thead>
<tr>
<th>Level of education</th>
<th>All Participants</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
</tr>
<tr>
<td>None</td>
<td>72</td>
<td>25.8</td>
<td>16</td>
</tr>
<tr>
<td>Primary Level</td>
<td>58</td>
<td>20.8</td>
<td>29</td>
</tr>
<tr>
<td>Preparatory</td>
<td>42</td>
<td>15.1</td>
<td>28</td>
</tr>
<tr>
<td>High School</td>
<td>51</td>
<td>18.3</td>
<td>38</td>
</tr>
<tr>
<td>Associate degree</td>
<td>18</td>
<td>6.5</td>
<td>17</td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>34</td>
<td>12.2</td>
<td>32</td>
</tr>
<tr>
<td>Master or higher degree</td>
<td>4</td>
<td>1.4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
<td>100</td>
<td>164</td>
</tr>
</tbody>
</table>
Examining table 4-2, it can be noted that male participants received more education than female participants. These results are expected due to gendered factors in the culture of Gaza Strip, which is relatively dominated by males, especially at the time when most of the participants were at school age. Also, these results are congruent with the statistics of the Palestinian Central Bureau of Statistics (PCBS) presented in the methodology chapter (PCBS, 2009a).

**Working Conditions**

Working conditions of all cardiac patient participants and a comparison between the working conditions of male and female participants are shown in table 4-3. The table indicates that the majority of participants (n=179, 64.2%) are not working, retired (n=19, 6.8%), or unable 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 had a part-time job. The total number of female patients who do not work is 113 participants, with a percentage of 98.2%. The high rate of unemployment among female participants could be related to the age of participants (154 participants {55.2%} were over the age of 60) and to the type of their disease, which limits their physical activity. This is in addition to the cultural background of the Palestinian community, which might contribute to limiting the employment among females, especially in these age brackets and their educational backgrounds.
Table 4-3: Working Conditions of Cardiac Patient Participants.

<table>
<thead>
<tr>
<th>Working Condition</th>
<th>All Participants</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
</tr>
<tr>
<td>Full-time</td>
<td>44</td>
<td>15.8</td>
<td>43</td>
</tr>
<tr>
<td>Part-time</td>
<td>11</td>
<td>3.9</td>
<td>10</td>
</tr>
<tr>
<td>Retired</td>
<td>19</td>
<td>6.8</td>
<td>18</td>
</tr>
<tr>
<td>Unable to work</td>
<td>21</td>
<td>7.5</td>
<td>18</td>
</tr>
<tr>
<td>Temporary contract</td>
<td>5</td>
<td>1.8</td>
<td>5</td>
</tr>
<tr>
<td>Do not work</td>
<td>179</td>
<td>64.2</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
<td>100.0</td>
<td>164</td>
</tr>
</tbody>
</table>

Hospital of Admission

Table 4-4 illustrates the frequency of number of cardiac patients admitted to each hospital and compares it to the rate of actual admission of cardiac patients to the same CCU at the same hospital in 2009. Examining the table, it can be seen that the percentage of cardiac patients admitted to Shifa Hospital (49.46%), which is the main hospital in Gaza Strip, is very close to the actual admission rate reported in 2009 (49.43%). On the other hand, it is noted that the actual rate of cardiac patients admitted to the CCU at Nasser Hospital (36.19%) is slightly more than the percentage of cardiac participants of this study who were admitted to the same unit (35.48%), while the actual rate of cardiac patients admitted to the CCU at Shuhada Al-Aqsa Hospital (14.38%) is a slightly less than the cardiac participants in this study who were admitted to the same unit (15.06%).
Table 4-4: Rate of Admission of Cardiac Patients to Hospitals with CCUs

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rate of admission for this study</th>
<th>Actual rate of admission in 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Shifa Hospital</td>
<td>138</td>
<td>49.46</td>
</tr>
<tr>
<td>Nasser Hospital</td>
<td>99</td>
<td>35.48</td>
</tr>
<tr>
<td>Shuhada Al-Aqsa Hospital</td>
<td>42</td>
<td>15.06</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Place of Living**

Table 4-5 illustrates the place of living for cardiac participants. Nineteen participants (6.8%) live in the Northern Governorate, 112 (40.1%) live in the Gaza Governorate, 46 (16.5%) live in the Mid-Zone Governorate, 75 (26.9%) live in Khanyounis Governorate, and 27 (9.7%) live in Rafah Governorate.

Table 4-5: Place of Living for Cardiac patient Participants

<table>
<thead>
<tr>
<th>Place of living</th>
<th>All participants</th>
<th>Male participants</th>
<th>Female participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td>Northern Governorate</td>
<td>19</td>
<td>6.8</td>
<td>7</td>
</tr>
<tr>
<td>Gaza Governorate</td>
<td>112</td>
<td>40.1</td>
<td>61</td>
</tr>
<tr>
<td>Mid-Zone Governorate</td>
<td>46</td>
<td>16.5</td>
<td>37</td>
</tr>
<tr>
<td>Khanyounis Governorate</td>
<td>75</td>
<td>26.9</td>
<td>44</td>
</tr>
<tr>
<td>Rafah Governorate</td>
<td>27</td>
<td>9.7</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
<td>100.0</td>
<td>164</td>
</tr>
</tbody>
</table>
**Living Conditions of the Cardiac Patient Participants**

The majority of cardiac patient participants (n=267, 95.7%) live with other family members, while the remainder (n=12 {3 male and 9 female participants}, = 4.3%) live alone. These results are not unusual, since it is common for elderly parents to live with one of their children, as the culture and the Islamic religion encourage Muslims to take care of their parents (Holy Quran, Chapter 17, verses 23 & 24 and Chapter 31, verses 14 & 15).

**Importance of Faith to Cardiac Patient Participants**

The preponderant majority (n=265, 95%) of cardiac patients reported that their faith was “very important” to them (table 4-6). Only one participant reported that his faith was “not important” to him, one participant reported that her faith was “slightly important” to her, four participants reported that their faith was “moderately important” to them, and eight participants reported that their faith was “important” to them. Such results reflect the religiosity of the people living in Gaza Strip and, also because people often become more religious and closer to God when they fall ill and when they get older (Koenig, 1998).
<table>
<thead>
<tr>
<th>Importance of Faith</th>
<th>All Participants</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
</tr>
<tr>
<td>Not important</td>
<td>1</td>
<td>.4</td>
<td>1</td>
</tr>
<tr>
<td>Slightly important</td>
<td>1</td>
<td>.4</td>
<td>0</td>
</tr>
<tr>
<td>Moderately important</td>
<td>4</td>
<td>1.4</td>
<td>2</td>
</tr>
<tr>
<td>Important</td>
<td>8</td>
<td>2.9</td>
<td>4</td>
</tr>
<tr>
<td>Very important</td>
<td>265</td>
<td>95.0</td>
<td>157</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
<td>100.0</td>
<td>164</td>
</tr>
</tbody>
</table>

Demographic Data of Healthcare Providers

A total of 12 healthcare providers were approached by the researcher to participate in this study. The sample included the nursing director, the head nurse of the CCU, the medical director of the CCU, and a senior cardiologist from each of the three hospitals that have CCUs in Gaza Strip. All 12 healthcare providers approached by the researcher agreed to participate in this study (response rate 100%). The majority of them were males (n=11) and only one participant was a female. Six of them had a nursing background and the other six had medical background. Ages ranged between 32 and 55 years with a mean of 43.4 years. The majority of them (n=9) were between 40 and 50 years, two participants were in their thirties, and one participant was in his fifties. Five of the nursing participants held a bachelor degree and one held a master degree. One of the
nursing staff is currently enrolled in a master’s program. All medical staff had either a master degree or an equivalent degree. General years of experience in the health care area ranged between seven and twenty seven years (mean 18.5 years), while experience in their current position ranged between 1-10 years, with a mean of 3.75 years. All healthcare provider participants with a nursing background had received their education in Gaza Strip, while all healthcare provider participants with a medical background had received their education outside Gaza Strip; one received her education from Algeria, three in the Ukraine, one from Belgium, and one from Austria. Table (4-7) summarizes the demographic data related to healthcare provider participants.

Table 4-7: Demographic Data of Healthcare provider Participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 40 years</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>40-50 years</td>
<td>9</td>
<td>43.4</td>
</tr>
<tr>
<td>More than 50 years</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Master</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Enrolled in Master</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master or equivalent</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Years of Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10 years</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>11-20 years</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>More than 20 years</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>5-10 years</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>In current position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaza</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Arab countries</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ukraine</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>European countries</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Study Variables

This study was designed to answer four main questions: (1) According to the cardiac patients admitted to the cardiac care units (CCU) in Gaza Strip hospitals, to what extent are their spiritual needs addressed? (2) To whom should the burden of providing spiritual care to cardiac patients admitted to CCU in Gaza Strip hospitals be left? (3) What are the administrative/organizational barriers to providing spiritual care to cardiac patients admitted to CCU in Gaza Strip hospitals? (4) What can be done to remove barriers to providing spiritual care and increase the frequency of providing spiritual care to cardiac patients admitted to CCUs in Gaza Strip hospitals?

Frequency of Provision of Spiritual Care

The frequency of providing spiritual care to cardiac patients by healthcare providers was measured by the Spiritual Rating Care Scale, (domain frequency) (SRCS-F) which was developed by Musa (2007). The SRCS-F contained 39 items and was divided by Musa into two major subscales: a) Spiritual Care Assessment Rating Scale, Domain Frequency (SCARS-F) which contained 18 items (items 1-18) and asked cardiac patient participants about the frequency of providing spiritual care assessment by healthcare providers, and b) Spiritual Care Intervention Rating Scale, Domain Frequency (SCIRS-F) which contained 21 items (19-39) and asked cardiac patient participants about the frequency of spiritual care interventions provided by healthcare providers (Musa 2007).
By examining the results of cardiac patients’ responses for Spiritual Care Assessment Rating Scale items (items 1-18) presented in table 4-8, it was found that the percentage of “absolutely not providing spiritual care assessment” by healthcare providers ranged between 82.15 (item 5) and 98.9% (item 13). 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 5 = 82.1%, item 8 = 88.5%, item 15 = 82.8%, and item 16 = 85.7%).

Examining the frequencies and percentages of the responses of cardiac participants for Spiritual Care Intervention Rating Scale items (items 19-39) presented in table 4-9, it can be seen that participants’ responses to these items had a great deal of variance. For example, the percentages for the choice “never” ranged between 12.9% for item 29 and 93.9% for item 22.

To better explain the results, the cardiac patients’ responses were converted into scores according to the following: ‘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 4-10 and 4-11 respectively.

As can be seen from table 4-10, 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.
Table 4-8: Spiritual Care Assessment Rating Scale (Frequency & Percentage)

<table>
<thead>
<tr>
<th>Item</th>
<th>Freq.</th>
<th>Absolutely</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
<th>Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>272</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>97.5</td>
<td>1.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 2</td>
<td>261</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>93.5</td>
<td>4.3</td>
<td>1.4</td>
<td>0.7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 3</td>
<td>266</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>95.3</td>
<td>2.9</td>
<td>1.4</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 4</td>
<td>252</td>
<td>20</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>90.3</td>
<td>7.2</td>
<td>2.2</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 5</td>
<td>229</td>
<td>33</td>
<td>10</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>82.1</td>
<td>11.8</td>
<td>3.6</td>
<td>1.8</td>
<td>0</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>Item 6</td>
<td>255</td>
<td>16</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>91.4</td>
<td>5.7</td>
<td>1.8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.1</td>
</tr>
<tr>
<td>Item 7</td>
<td>268</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>94.6</td>
<td>4.3</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>Item 8</td>
<td>247</td>
<td>20</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>88.5</td>
<td>7</td>
<td>3.6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>Item 9</td>
<td>253</td>
<td>15</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>90.7</td>
<td>5.4</td>
<td>3.2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>Item 10</td>
<td>267</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>95.7</td>
<td>2.5</td>
<td>1.8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 11</td>
<td>265</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>95.0</td>
<td>3.6</td>
<td>1.4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 12</td>
<td>257</td>
<td>12</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>92.1</td>
<td>4.3</td>
<td>3.6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 13</td>
<td>276</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>98.9</td>
<td>0.7</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 14</td>
<td>261</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>93.5</td>
<td>2.5</td>
<td>1.8</td>
<td>0.4</td>
<td>1.4</td>
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<td>Item 15</td>
<td>231</td>
<td>21</td>
<td>23</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>82.8</td>
<td>7.5</td>
<td>8.2</td>
<td>0.4</td>
<td>0.4</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>Item 16</td>
<td>239</td>
<td>26</td>
<td>12</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>85.7</td>
<td>9.3</td>
<td>4.3</td>
<td>0</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 17</td>
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<td>20</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>91.4</td>
<td>7.2</td>
<td>0.7</td>
<td>0</td>
<td>0.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item 18</td>
<td>267</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>%</td>
<td>95.7</td>
<td>2.9</td>
<td>0.7</td>
<td>0</td>
<td>0.4</td>
<td>0</td>
<td>0.4</td>
</tr>
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</table>
Table 4-9: Spiritual Care Intervention Rating Scale (Frequency & Percentage)

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The mean score for performing spiritual assessment by healthcare 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 4-10). Such very low scores reflect the shortage of providing spiritual assessment by healthcare providers to cardiac patients.

Table 4-10: Spiritual Care Assessment Rating Scale Scores (Descriptive Statistics)

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Similarly, by examining table 4-11, 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 interventions by healthcare 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, with a standard deviation of 12.134 (table 4-11). Such very low scores reflect the marked shortage in providing spiritual interventions by healthcare providers to cardiac patients.

Table 4-11: Spiritual Care Interventions Rating Scale Scores (Descriptive Statistics)

<table>
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<th>Maximum</th>
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<th>Std. Deviation</th>
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<td>11.73</td>
<td>26.006</td>
</tr>
<tr>
<td>Item 27</td>
<td>.00</td>
<td>100.00</td>
<td>3.51</td>
<td>12.880</td>
</tr>
<tr>
<td>Item 28</td>
<td>.00</td>
<td>100.00</td>
<td>5.87</td>
<td>20.063</td>
</tr>
<tr>
<td>Item 29</td>
<td>.00</td>
<td>100.00</td>
<td>78.61</td>
<td>34.323</td>
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<tr>
<td>Item 30</td>
<td>.00</td>
<td>100.00</td>
<td>38.36</td>
<td>36.704</td>
</tr>
<tr>
<td>Item 31</td>
<td>.00</td>
<td>100.00</td>
<td>33.30</td>
<td>37.025</td>
</tr>
<tr>
<td>Item 32</td>
<td>.00</td>
<td>100.00</td>
<td>49.91</td>
<td>39.884</td>
</tr>
<tr>
<td>Item 33</td>
<td>.00</td>
<td>100.00</td>
<td>34.77</td>
<td>30.597</td>
</tr>
<tr>
<td>Item 34</td>
<td>.00</td>
<td>100.00</td>
<td>50.99</td>
<td>31.543</td>
</tr>
<tr>
<td>Item 35</td>
<td>.00</td>
<td>100.00</td>
<td>47.75</td>
<td>32.103</td>
</tr>
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<td>Item 36</td>
<td>.00</td>
<td>100.00</td>
<td>13.80</td>
<td>25.313</td>
</tr>
<tr>
<td>Item 37</td>
<td>.00</td>
<td>100.00</td>
<td>4.23</td>
<td>14.333</td>
</tr>
<tr>
<td>Item 38</td>
<td>.00</td>
<td>100.00</td>
<td>33.00</td>
<td>27.961</td>
</tr>
<tr>
<td>Item 39</td>
<td>.00</td>
<td>100.00</td>
<td>50.09</td>
<td>31.039</td>
</tr>
<tr>
<td>All items</td>
<td>.00</td>
<td>80.95</td>
<td>24.68</td>
<td>12.134</td>
</tr>
</tbody>
</table>
Table 4-12 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 in providing spiritual care by healthcare providers to cardiac patients admitted to CCUs at Gaza Strip hospitals.

Reporting on spiritual needs of patients has been evident in the international literature over recent few 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 different patient categories (Fagerström, Erikson, & Engberg, 1999; Narayanasamy, Clissett, Parumal, Thompson, Annasamym, & Edge, 2004; Taylor, 2006), while others focused on exploring the frequency of providing spiritual care to several categories of patients (Taylor, Highfield, and Amenta, 1999; Dixon, Lim, Powell, Fisher, 2000;

Table 4-12: Summary of Descriptive Statistics of Assessment And Interventions Scales Items.

<table>
<thead>
<tr>
<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual Care Assessment</td>
<td>.00</td>
<td>38.16</td>
<td>2.58</td>
<td>5.576</td>
</tr>
<tr>
<td>Rating Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual Care Intervention</td>
<td>.00</td>
<td>80.95</td>
<td>24.68</td>
<td>12.134</td>
</tr>
<tr>
<td>Rating Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both Assessment &amp;</td>
<td>.00</td>
<td>51.28</td>
<td>14.54</td>
<td>7.573</td>
</tr>
<tr>
<td>interventions scales</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In a study conducted by Fagerström, Erikson, & Engberg (1999), the authors reported that in spite of the fact that many patients found it was difficult to talk about their spiritual needs, participants reported the following spiritual/existential needs: the need for respecting their humanity, to be seen and understood, to be welcomed, giving and receiving love, the need to experience contact and closeness, and to feel that they have a meaning in life.

In a study similar to Fagerström’s et al. (1999), Taylor (2006), using a semi-structured interview approach, 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 (2006) 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” (p. 729). From a different perspective, Narayanasamy et al. (2004) found out that the most important 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
resolve connect; listening to their concerns, comfort and reassurance; assistance in religious practice; and listening to patients’ concerns.

Other studies focused on investigating how often spiritual needs were provided by healthcare 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” (Taylor & Mamier, 2005, p. 260), the researchers observed that there were variations in the responses of cancer patients and their family caregivers to items reported about the frequency of providing spiritual care. The majority (more than 50%) of patients responded with either strongly disagree or disagree for 15 items out of the 20 items included in the list. In another study conducted by Murray et al. (2003), who interviewed 149 terminally ill patients and family members who took care of them, participants reported that there were often spiritual needs of the patients and the caregivers left unmet by their general practitioners. The results of this study are congruent with those reported in the literature.

In another study conducted by Kuuppelomäki (2001), that included 328 nurses, participants reported that they were deficient in their willingness and readiness to provide spiritual care to terminally ill patients. Furthermore, half of the nurses included in the study reported that they rarely offered spiritual care and support to their patients. Along the same lines, in an online survey of 4,054 British nurses surveyed by McSherry and Jamieson (2010), only 5.3% of nurses 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. (2000) found that the majority of 1,124 cardiac patients reported unmet spiritual needs after discharge from the hospital. On the other hand, after an extensive review of literature, Clark et al. (2003) concluded that the majority of hospitalized patients experienced some form of emotional and spiritual distress and that healthcare providers did not wholly address these needs. Similarly, Feudtner et al. (2003) 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. For example, Taylor, Highfield, and Amenta (1999) reported that direct spiritual care was rarely provided by oncology nurses, about 57% of Stranahan (2001) participants reported that spiritual care was never or rarely provided to them, and about 52% of nurses participated in Kuuppelomaèki’s (2001) study reported that they rarely provided spiritual support to their patients. Finally, in his study, Mussa (2007) determined that there was a severe shortage in assessment of spiritual needs and provision of spiritual care to Jordanian cardiac patients, which is congruent with the results of the present study. These findings reflect the fact that the deficiency in provision of spiritual care is a universal phenomenon and not limited to Gaza Strip.

Despite the many studies that identified spiritual needs of patients as important for recovery, the results of this study along with the findings of other several studies reported on the lack of spiritual care for different groups of patients. Such results should call the attention of healthcare policy makers to the question of why spiritual care is not provided, what the barriers to providing spiritual care actually are, and what can be done to overcome these barriers to provide spiritual 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 cardiac patient 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 (Islamic clergy) (n=27, 9.7%) ranked third. While eleven participants (3.9%) preferred that no one offer spiritual care to them, only six participants (2.2%) preferred that physicians should provide spiritual care to them (Table 4-13).

The results reported by cardiac patient participants were expected. This is because nurses are available to them and can be reached 24/7 during any time. On the other hand, physicians usually spend very little time with them during the day. As a rule, physicians spend some 5-10 minutes with each patient during the morning round, if the patient is in a stable condition. 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 a limited number of minutes twice a day.

Table 4-13: The Most Appropriate Person to Provide Spiritual Care to Cardiac Patients.

<table>
<thead>
<tr>
<th>Who is to provide spiritual care?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>159</td>
<td>57.0</td>
</tr>
<tr>
<td>Family Members</td>
<td>72</td>
<td>25.8</td>
</tr>
<tr>
<td>Imam (Clergy)</td>
<td>27</td>
<td>9.7</td>
</tr>
<tr>
<td>No one</td>
<td>11</td>
<td>3.9</td>
</tr>
<tr>
<td>Doctors</td>
<td>6</td>
<td>2.2</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
<td>100.0</td>
</tr>
</tbody>
</table>
When the same question was put to the healthcare providers, the answers varied. Five participants with nursing backgrounds responded that nurses usually spend more time with the patients; therefore, they should provide spiritual care to their patients. One cardiologist mentioned “for sure, it should be provided by a doctor.” Another cardiologist mentioned that spiritual care should be provided by a psychologist or a social worker. Another cardiologist responded; “it should not be a doctor, not a nurse, or an Imam. It should be provided by someone who has transparency and love to God.”

Finally, four of the participants agreed that the provision of spiritual care should not be monopolized by a specific person, but should be the task of the entire healthcare team:

There is no specific person (who should provide spiritual care). It should be the work of all members of the healthcare team. It should not be monopolized by any members of the team. There should be cooperation and communication between members of the healthcare team and there should be a written spiritual plan exactly like there is a medical care plan and a nursing care plan. If there is no communication between members of healthcare team, the work of someone can be sabotaged by another member of the healthcare team. Family members also can participate and play a role in providing spiritual care.

By examining the literature, it was found that several studies tackled this topic and wondered ‘who should provide spiritual care?’ Among those reported in the literature as the most helpful to patients with spiritual care and spiritual support needs were nurses along with family members, physicians, friends, and clergymen (Reed, 1991; Highfield, 1992; Camp, 1996; Ross, 1998; Taylor, 2002; Handzo & Koenig, 2004; Pronk, 2005; Sawatzky & Pesut, 2005; Taylor, 2005; Baldacchino, 2006; Musa, 2007). 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
(2002) reported that family members, friends, and clergy were the most convenient people to provide patients with spiritual care. Similarly, in Reed's (1991) study, nurses ranked behind family members, friends, and clergy and before physicians as the most appropriate people to provide them with spiritual care and spiritual support; that is consistent with the findings of the present study. Different results were reported by participants in Highfield’s (1992) study. Patients reported that they will turn to their physician most likely, rather than to their nurse, to obtain spiritual care. Similar findings were reported by King and Bushwick (1994), as 77% of hospitalized patients reported that they would like for their physicians to meet their spiritual care needs. This does not agree with the results of the present study.

Some studies sought the perception of nurses about who should provide spiritual care. In a study conducted by McSherry and Jamieson (2010), 92.6% of nurses participating in the study felt that the provision of spiritual care was the responsibility of nurses, chaplains, other health care professionals, and family members and friends. In another study by Kristeller, Zumbrun, & Schilling (1999), 47% of the 267 oncology nurses included there perceived themselves to be in the front position to provide spiritual care to their patients, which is consistent with the perception of nurses participating in the present study.

From a medical perspective, Pronk (2005) 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” (p. 421). On the other hand, Sawatzky and Pesut (2005) 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 (2009) 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 to the patients may give them the advantage of being an excellent source for spiritual assistance at the time it is needed, which is congruent with the results of the present study.

Furthermore, the responses of cardiac patients of this study are consistent with Musa’s (2007) investigation. Musa conducted a similar study in Jordan, which shares most of the characteristics of the Palestinian population regarding religion, culture, and demographics. Musa asked cardiac patients who had cardiac bypass surgery to rank the most convenient person to provide them with spiritual care. The majority of his participants (90.5%) reported that nurses were the most appropriate persons to provide spiritual care to them. Table 4-14 illustrates a comparison of the participants’ responses of the present study and responses of participants of Musa’s study about the most appropriate person to provide spiritual care for cardiac patients.

The variances in the responses to the question ‘who should provide spiritual care?’ is not unique to the results of this study. The question of ‘who should provide spiritual care to patients?’ was posed by many authors, without coming to a common
Table 4-14: The Most Appropriate Person to Provide Spiritual Care to Cardiac Patients: a Comparison of Results of This Study and Musa’s (2007) Study

<table>
<thead>
<tr>
<th>Who is to provide spiritual care</th>
<th>This study</th>
<th>Musa’s study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Nurses</td>
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</tr>
<tr>
<td>Doctors</td>
<td>6</td>
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</tr>
<tr>
<td>Friends</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>279</td>
<td>100.0</td>
</tr>
</tbody>
</table>

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 position is not available in the health care system in Gaza Strip. Vande Creek & Lyon (1997) 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 (2003) argued that chaplains are the specialist professionals who are prepared to provide spiritual care. Kliewer & Saultz (2006) added that when clinicians face a complex spirituality-related situation, they need to refer them to the specialists, the chaplains. Similarly, Handzo and Koenig (2004, p. 1242-1243) depicted the roles of the clinicians and the chaplains:

In general, the role of the physician is to assess spiritual needs as they relate to healthcare (i.e., briefly screen) and then refer to a professional pastoral caregiver as indicated (i.e., to address those needs). The chaplain is the spiritual care specialist on the healthcare team and has the training necessary to treat spiritual
distress in all its forms. Seeing the physician as the generalist in spiritual care and the chaplain as the specialist is a helpful model.

In spite of the fact that Vande Creek (1997) 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, healthcare providers need to know when and under what circumstances to refer their patients to pastoral care (Astrow; Puchalski; & Sulmasy, 2001). Similiarly, Clark et al. (2003) argued that healthcare providers, including nurses, doctors, clinicians, and other care givers, have important roles in providing spiritual care.

As is evident in the literature, spiritual care can be provided by multiple health care professionals; this issue is congruent with the present study. McSherry and Jamieson (2010) advocated the idea of having a multidisciplinary emotional and spiritual care team. According to McSherry and Jamieson, the team would be responsible for coordinating resources, interventions, communications, and organizing learning and training for staff to improve their abilities to meet the spiritual needs of their patients.

Qualitative Data Analysis

This section includes the analysis of qualitative data which were collected from the semi-structured interviews with the healthcare provider participants. Collected data covers mainly two research questions related to barriers to providing spiritual care and how to overcome these barriers.
Barriers to Providing Spiritual Care

After examining the responses of the healthcare providers, there were many barriers to provision of spiritual care that had emerged. The emerging barriers were coded into the following themes: inadequate education and training, ambiguity about spirituality, inadequate time, shortage of staff, policy-related barriers, and individual-related barriers.

Inadequate Education and Training

In general, there was very little (if any) formal or non-formal education that covered the topic of providing spiritual care. All healthcare provider participants mentioned that they did not receive any formal education about spiritual care, with the exception of one participant (one of the head nurses), who mentioned that the topic was tackled slightly during his bachelor’s degree study program, although it was not included during his graduate study program for the master’s degree. Furthermore, two participants (medical directors) mentioned that they never heard about spirituality and spiritual care. In the remarks of one:

Actually, there was nothing (related to spiritual care) in my education. The organic medicine was the major topic in our study. Spirituality, if it was mentioned, it was just mentioned as a way of emotional support, not any more. But at the practical level, spiritual care is not provided.

One head nurse added:

Frankly, we used to hear about providing a holistic nursing approach that includes physical, emotional, psychological, and spiritual care. But at the practical level,
we were never taught about how to provide spiritual care to our patients. That’s why we do not do it.

The responses of participants indicated that spirituality and spiritual care were not part of their health education. Two participants mentioned that it was present as a vague concept. They mentioned that some teachers talked about the topic during some courses, especially those related to ethics, and that was usually related to personal interest of those teachers and was not part of the educational material contents. One participant noted:

The issue of spirituality was not clear in the curriculum. It was impeded in some courses such as ethics course and other courses related to dealing with patients. It was not pure spiritual care, but it was an issue that somewhat related to spiritual care.

In spite of the absence of formal education about spiritual care, some participants obtained relevant knowledge about spirituality from religious speeches at the mosques, from media, and from surfing the Internet. Other participants mentioned that through their practical experience and through personal interest, they gained some clues about the importance of providing spiritual care and about how to provide spiritual care to their clients. This was reflected on by one of the cardiologists, who stated:

Frankly, during our studies, nobody paid any attention to spiritual care. But during our practice, we recognized the importance of providing spiritual care for all patients in general and particularly for cardiac patients.

Another participant (a head nurse) confirmed:

At the formal and non-formal levels, the topics of spirituality and spiritual care were not involved, but through my personal studies (depending on my religious beliefs), I was able to learn some skills that helped me to provide some spiritual care to my clients.
At the non-formal level, the issue of spirituality and spiritual care was likewise not included in the in-service education arranged by the hospitals. A small number of participants (two) mentioned that in a few sessions of in-service education about palliative care, spirituality and spiritual care were touched on slightly. For example, one of them commented:

In reality, I was involved in many in-service education courses which influenced me a lot. Once we were visited by an Australian physician, who was older than 80 years, and she drew our attention to many issues, including providing spiritual care to our clients.

The results of this study are congruent with many studies that reported a lack of education and training in regard to spiritual care (Orchard, 2000; Feudtner, Haney & Dimmers, 2003; Fletcher, 2004; Pronk, 2005; Kliwer & Saultz, 2006, Van Leeuwen, Tiesinga, Post, & Jochemsen, 2006; Chan, 2009, McSherry & Jamieson, 2011).

For example, out of 4,054 nurses and student nurses surveyed by McSherry & Jamieson (2011), 79.3% reported that they did not receive enough educational preparedness and training to meet their patients’ spiritual needs. Similarly, McSherry (1997) found that 71.8% of nurses felt that they did not receive sufficient education about spiritual care. Along similar lines, Stranhan (2001) found that 57% of nurses felt that they had had inadequate preparation about providing spiritual care.

While some studies revealed lack of education and training of healthcare providers in matters of spirituality, other studies (Greenstreet, 1999; Shih, Gau, Mao, Chen & Lo, 2001; Chung, Wong, & Chan, 2007) revealed that teaching spirituality is essential and will be reflected in clinical practice.
Despite the fact that participants in the investigation by Van Leeuwen et al. (2006) reported that basic communication skills needed to provide spiritual care were taught to them during their studies, they felt that they needed more training related to spiritual care that involves personal spiritual awareness, spiritual conversation methods, more information about spirituality, religion, the traditions, and the language that go with spirituality. Furthermore, Murray et al. (2003) added that general practitioners needed some support and training to help them in identifying spiritual needs and providing appropriate spiritual interventions to their clients. All these studies support the results of the present investigation.

Furthermore, many researchers asserted that educational preparation to provide spiritual care is essential to prepare healthcare providers to provide spiritual care. Therefore, absence or inadequate inclusion of spirituality in health education curricula may lead to poor and improper provision of spiritual care (Dover & Bacon, 2001; McSherry, 2006, Ross, 2006; Van Leeuwen, 2006). Lemmar (2005) further added that nursing schools need to address spirituality and spiritual care in their curricula.

Ambiguity about Spirituality

The concept of spirituality was not clear to most of the healthcare provider participants. The researcher noted that it was very difficult for them to define spirituality when they were asked to do so. In fact, some of the participants (two cardiologists) could not define it and when they were asked to define spirituality, they replied to the
researcher “you define it for us. You are a doctoral student and have more knowledge about this topic than we do.”

Although, most of the healthcare provider participants (especially nursing staff) tried to define spirituality, there was no common agreement about what spirituality and spiritual care are. In general, it was noticed that all participants, when they tried to define spirituality, connected it to ALLAH (God) and religion. For example, one of the nursing directors tried to define spirituality in this way:

The individual is very weak during the time of sickness. During sickness time, treatment does not only include medicine, but they need emotional and spiritual support and need to be reminded that cure is in the hands of ALLAH and everything happens to that individual holds something good included in it. So, spiritual care involves advising patients to worship ALLAH and to get closer to Him, reciting Quran, and reminding him/her to believe in destiny. Performing these issues will improve his spiritual and psychological status which will improve his health condition and make his or her cure faster. Surely if the patient has spiritual or psychological distress, his or her cure will be delayed or he/she may not get well at all.

Another participant (head nurse) mentioned that:

It involves the inclusion of the concept of religiosity and the belief in ALLAH when dealing with the patients. This means connecting the issue with destiny and fate and the belief that everything comes from ALLAH, including wellness and disease. But to define it as a term, there is no clear definition.

When one of the chief cardiologists tried to define spirituality, after admitting that it was difficult to define it, he said:

When one hears about spiritual care, immediately one will think about religion. Our religion (Islam) covers spirituality well and our society is a religious one. Therefore, it is easy to convince patients by using the basics of religion. One of the most important factors that play a very important role in our society is its beliefs. Therefore, when we communicate with our patients, we use religious terms and read some verses from the Holy Quran. This helps us to build a trust relationship with our patients and we feel that the patient becomes relaxed and more comfortable. This issue we observe and we experience it ourselves.
One of the cardiologists involved in this study described himself as secular. When he was asked to define spirituality, he replied: “it is a branch of medicine that produces unreliable results.” Then he continued:

I need its definition from you (the researcher). I reject this issue as I believe in organic and physical medicine. I believe in the psychological and social aspects but I do not believe in spirituality, since its concept is not clear to me. Therefore, I do not accept it.

The vagueness and ambiguity about spirituality and spiritual care is not unique to the findings of this study. Many researchers and authors have reported about the vagueness and ambiguity of spirituality and how difficult it is to define it, as one is trying to define something that is intangible and mystical (Reed, 1992; Macrae, 1995; Clark, 1997; Greasley, Chiu, Gartland, 2001; Lemmer, 2005; Sawatzky & Pesut, 2005). Furthermore, (Narayanasamy, et al., 2004) mentioned that several scholars in spirituality (such as Oldnall, McSherry, Draper, and MacKinlay) find that spirituality is an elusive concept when they try to define it. For example, Moya & Brykczynska (1992) wrote “the human spirit is not easy to define and, perhaps, there is an argument that . . . the human spirit is indescribable.” In the same vein, McSherry & Jamieson (2011, p. 1761) described spirituality as “an umbrella term because beneath the word there is a wide range of individual meanings, associations and interpretations that individuals may use to define and articulate understanding.” Furthermore, In spite of the fact that many of the nurses participating in McSherry’s & Jamieson (2011) study agreed with several fundamental items pertaining to spirituality, analysis revealed that there was some uncertainty regarding other items of the scale used in the study to describe spirituality.
The ambiguity about spirituality is evident in the numerous definitions available in the literature. Deborah Rufener (2011, p. 5) commented about this abundance of definitions in the literature:

The varying content of these definitions can be a source of confusion to nurses as they address components of assessment, intervention, and evaluation of spirituality. The term may be defined differently between nurses, between nurse and patient, between nurse and family, as well as between the patient and their loved ones.

Finally, it was not only that healthcare providers who perceived the ambiguity of spirituality; patients likewise perceived it as vague (Fagerström et al., 1999).

It was evident in the attempts of the healthcare provider participants in this study that almost all of them coupled spirituality with religion. This is not strange, since as the preponderant majority of residents in Gaza Strip are Muslims, and part of the Islamic doctrine is to believe in Allah and to adhere to a belief in the power of fate. The responses of healthcare providers in the present study are congruent with many studies and definitions that perceived the premise of spirituality as being basically a synonym of ‘religion,’ and generally used interchangeably with this conceptual complex (Taylor, Amenta, & Highfield, 1994; McSherry, 1998; Carroll, 2001; Narayanasamy & Owens, 2001; Stranahan, 2001; Swinton, 2001; McBrien, 2010). In fact, in several studies (Harrison and Burnard, 1993; Narayanasamy, 1993; Ross, 1997; Bruce 1998), it was noted that nurses were confused and regarded spirituality as tantamount to ‘religion.’ McSherry’s & Jamieson (2011) added that healthcare professionals are uncertain about distinguishing between religious and spiritual care. The results of the present investigation clearly are in keeping with the research literature, especially given that Gaza is considered a predominantly religious society.
Inadequate Time

Half of the participants among the healthcare providers mentioned that lack of time was a barrier to providing spiritual care. As a rule, staff working at the CCUs are relatively busy, since they are caring for patients who are critically ill. One of the cardiologists commented:

Usually doctors do not have enough time. They want to see their patients [i.e. cardiac patients hospitalized in the CCU and other departments] during the morning round, and then they need to hurry up to the out-patient clinic to see their patients there. Also nurses do not have enough time, because they are busy in providing basic care.

One of the head nurses agreed with the cardiologist and said:

Nurses do not have enough time to provide spiritual care. They are usually very busy providing basic care to their patients, since patients are usually in complete bed rest and therefore they are completely dependent on nurses.

One of the reasons that do not allow enough time for healthcare providers is what one of the participants called the ‘bed capacity crisis’:

Because of the current political situation that we have here in Gaza Strip, we have a bed capacity crisis. There are a limited number of beds in the CCU. On many occasions, we are forced to discharge patients early to provide a bed for a newly admitted patient. This will not allow time for us to provide such care for our patients.

Lack of time was reported as a barrier to provide spiritual care in many studies by numerous researchers, especially in the nursing literature (Orchard, 2000; Carroll, 2001; Dover and Bacon, 2001; Kuuppelomaèki 2001; Lemmer, 2005; Kliewer & Saultz, 2006; Van Leeuwen, Tiesinga, Post, & Jochemsen, 2006; Williams, 2008; Chan, 2009). Lack of time was also reported as a major barrier to providing spiritual care by general
practitioners (Murray et al. 2003) and physicians (Koeing, 2004). Williams (2008) added that time constraints will affect the energy of staff and healthcare providers will as a result not be “attentive to deeper dimensions of patients’ concern” (p. 4), including their spiritual needs.

In fact, time was not perceived as a barrier to providing spiritual care to patients by healthcare providers only, but patients themselves think that some healthcare providers such as nurses are too busy and do not have enough time to provide spiritual care to them. In spite of that, some of these participants felt that occasionally, time could indeed be made available (Van Leeuwen, et al., 2006).

Despite the fact that half of the healthcare provider participants mentioned that they could not provide spiritual care to cardiac patients, some of them disagreed and noted that there is no need to set a specific time to provide spiritual care. Spiritual care can be provided simultaneously while doing other tasks.

Time is not really a barrier. While I am bathing the patient or drawing a blood sample, I can provide spiritual care. I can talk to the patient while I am doing other tasks. One needs to know how to use one’s time efficiently.

Another participant added:

The problem is not in the availability of staff or time. Providing spiritual care needs someone who believes in it and has good communication skills. This is in addition to experience and training. So that I believe that the problem is not in the number of staff.

Based upon reviewed research results, Williams (2008) agreed with these participants that time could not be a barrier to providing spiritual care, since some research findings reported that some personal characteristics such as perceived ability and willingness to be involved in providing spiritual care are what contribute to providing
spiritual care --- rather than time constraints. In fact, some palliative care doctors reported
that even the presence of such personal characteristics will not allow those who have the
ability and willingness to provide spiritual care all the time (Cassidy, 1998). Along
similar lines, Grotbo (2000) added that healthcare providers can provide spiritual care
while at the same time providing physical care.

*Shortage of Staff*

Another barrier to providing spiritual care according to healthcare providers was
shortage of staff, a lack of both physicians and nurses. One of the nursing directors
reflected:

If I follow the international ratio of patient: nurse, I need 10 nurses for eight beds
in the CCU. Most of the time, the maximum number of nurses I have is four
nurses (the head nurse and three other nurses). If we are to provide holistic
nursing care, including the spiritual part, I will not be able to do so with this lack
of staff I have. Therefore, my staff are usually stressed with work overload. I
believe that they themselves need someone to provide them with spiritual care.

Another head nurse confirmed what was mentioned before and added that usually
when they need new staff, they ordinarily get new graduates who lack the experience to
work with cardiac patients:

When there is inadequate number of staff, there will be a work overload on them
(on nurses) which will affect their ability to provide the basics of care. In such
conditions, how we can expect them to provide spiritual care. Another thing that I
would like to add is that when we need a new staff member, usually, I get new
graduate nurses who lack the work experience in general and need a long time to
be oriented and trained to become real CCU nurses.
The issue of shortage of staff as a barrier to providing spiritual care was commonly reported by nursing staff participants. Only one of the doctors mentioned it as a barrier: “there is a lack of the number of doctors and nurses in the unit, therefore, they will not have enough time to provide spiritual care.”

Besides the shortage of staff, instability of health care team members was another staff-related barrier which was mentioned by some of the healthcare providers. They mentioned that such an issue will impede provision of spiritual care. Occasionally, rotation of nursing staff takes place and new graduates are assigned to work at the CCU. According to one of the nursing staff, such instability in staff members will affect their commitment to work:

The nursing team is not stable. Sometimes we have some staff from other departments because of rotation of staff. At other times, we have new graduates. Some of our staff are recruited and promoted to other managerial positions. Such instability in staff will affect their commitment to work.

The result of this study is supported with the literature. Several researchers reported that shortage of staff was a barrier to providing spiritual care (Ross 1994, Harrington, 1995, McSherry, 1998, Carroll, 2001; Feudtner, Haney & Dimmers, 2003; McSherry, 2006; Chan, 2008). The literature did not report about the inadequate staffing of healthcare providers staff only, but Feudtner, et al. (2003) also reported that there were shortages in pastoral staff. The lack of pastoral staff was reflected by the comments of two of the pastoral staff who were working in busy hospitals with a limited pastoral care staff: “I tend to live in the ICUs,” and “We obviously cannot provide adequate spiritual care to anyone with these kinds of numbers. We do crisis” (Feudtner, et al., 2003, p. 70).
Policy-Related Barriers

The next reported barrier was related to the available health policies and health policy decision makers. More than a half of the healthcare provider participants mentioned that there was no clear policy about the inclusion of spiritual care in their job descriptions.

One of the head nurses mentioned:

There is generally a lack of job description, a limited number of team members, low job satisfaction, and inadequate salaries among the team members. Therefore, before requesting from staff to provide spiritual care to their patients, policy makers should improve the environment that influences the ability of the health care team to provide spiritual care.

Another head nurse added:

This organization (the hospital) belongs to the Ministry of Health, which I think is not interested in providing spiritual care. If they (health policy makers) are interested in spiritual care, they should arrange for training and distribute handouts related to spiritual care and the follow this up by surveying the patients and seeing if they can accept this issue and to measure their level of satisfaction in this regard.

Furthermore, one of the cardiologists pointed out that health policy makers in Gaza Strip themselves are not aware of the importance of providing spiritual care to hospitalized patients: “Usually, health policy makers are not aware of the importance of providing spiritual care; therefore, how we can expect them to pay attention and adopt a policy of providing spiritual care.”

Finally, some of the healthcare providers mentioned that provision of spiritual care is not included in their job descriptions:
We encourage providing spiritual care although we do not offer it. We belong to the Ministry of Health, which establishes the related policies, the nature of the work, and who is to perform each task. It is not part of my job description, so that some health care providers would wonder why they should provide spiritual care while it is not part of their job.

The results of this part of the study contradict with the literature in one area and agrees with it in another. In Gaza Strip, there is no policy for spiritual care and none regarding the role of healthcare providers in this area. In fact, the words ‘spiritual’ and ‘spirituality’ were not mentioned at all in the code of nursing (Palestinian Council of Health, 1996). On the other hand, in most developed countries, there is a clear policy about the responsibility of healthcare providers, especially doctors and nurses, when it comes to providing spiritual care. For example; in the United States, the Joint Commission on Accreditation for Health Care Organizations (JCAHCO) requires that patients’ spiritual beliefs, practices and needs be assessed and met by healthcare providers (Clark, Drain, & Malone, 2003). Other countries such as the United Kingdom (National Association of Health Authorities and Trusts, 1996; Nursing and Midwifery Council, 2002; Department of Health, 2003; National Institute for Health and Clinical Excellence (NICE), 2004; Multi-Faith Group For Healthcare Chaplaincy, 2006), Scotland (Scottish Government 2009), Norway (Norwegian Nursing Association, 2001), Malta (Malta Code of Ethics, 1997), and recently Israel (Bentur, Resnitzky, Sterne, 2010) also included the provision of spiritual care in their codes of practice.

Beside the local mandates made by each individual country, other international sources and organizations mandate healthcare providers to meet spiritual needs of patients. For example, the code of the International Council of Nurses identified

Despite the clear health policies about the role of healthcare providers related to provision of spiritual care and the acknowledgment of some healthcare providers (nurses) that it is part of their role (Ross, 2006), many of the nurses interviewed by McSherry & Jamieson (2010) were uncertain about their role in providing spiritual care. Ironically, some nurses believed that providing spiritual care is not a nursing matter (Kuuppelomaèki, 2001). On the other hand, although doctors had clearly defined roles, including spiritual care, according to Williams (2003, p. 4) “spiritual care of patients is at best a secondary rather than a primary role.” Similarly, all general practitioners interviewed by Murray et al. (2003) recognized their role to provide spiritual care to their terminally ill patients, but they were constrained to do so, thinking that their patients might not raise this topic.

Individual-Related Barriers

Finally, other barriers reported by healthcare providers were individual-related. For example, some healthcare providers themselves lacked the concept of spirituality. Many nurses (especially new graduates) themselves lack spirituality. So how can they provide it? For example, I have 20 nurses in the unit; I believe that only five of them provide spiritual care. Others would say: I have so much work to do, I do not have time most of the time; I do not get my salary on time, so why should I do this, I am not an Imam [a clergyman]?
Besides lacking the concept of spirituality, a lack of religiosity, lack of experience, and lack of communication skills were reported by some of the healthcare providers as barriers to providing spiritual care.

The results of this study were consistent with other studies. For example, lack of experience was reported as a barrier to providing spiritual care by Orchard (2000) and Williams (2008). One of the factors mentioned by Ross (2006) after an extensive literature review that could enhance provision of spiritual care is awareness of healthcare professionals about their spirituality, including their beliefs and life experience.

Other studies correlated between the perception of healthcare providers and the likelihood to provide spiritual care. For example, Chan et al. (2006), Chung et al. (2007) and Chan (2009) found that nurses who had a high perception level about their own spirituality were more likely to provide spiritual care to their patients. Similarly, Stranahan (2001) found that the perception of nurses who felt that providing spiritual care is not essential to their patients had had a negative influence on their practice in providing spiritual care. Kuuppelomaëlki (2001) found that lack of religious conviction among healthcare providers and unfamiliarity with spirituality would contribute to inadequate provision of spiritual care to their patients.

Overcoming Barriers to Providing Spiritual Care

When healthcare providers participating in this study were asked to suggest some solutions to overcome the barriers and challenges that interfere with provision of spiritual care for cardiac patients admitted to CCUs at Gaza Strip hospitals, there were many
suggestions made by them. These suggestions were categorized as follows: policy change, organizational interventions, including spirituality in health education (formal and informal) and other miscellaneous interventions.

Policy Change

The majority of healthcare providers thought that health policy makers themselves are unaware of the importance of providing spiritual care to patients in general and to cardiac patients in particular. Therefore, they think that health policy makers need to be acquainted with research results that reflect the relationship between spiritual care provision and patients’ outcomes: “Policy health makers should be fully oriented to the subject (spiritual care) and pay interest to it.”

Other participants suggested that a new policy to involve providing spiritual care ought to be adopted by the Ministry of Health. One of the cardiologists said:

We need to introduce a proposal to health policy makers that clarifies the importance of providing spiritual care, including the positive effects of providing spiritual care to cardiac patients. Therefore, a policy of providing spiritual care can be adopted and spiritual care then will be a part of the physicians’ job. For this, they [health policy makers] need to provide healthcare providers with training about giving spiritual care.

In fact, some healthcare providers suggested not only the adoption of spiritual care policy, but also recommended there be a follow-up for its implementation and then a process to evaluate its effect on cardiac patients:

The Ministry of Health should adopt a policy of providing spiritual care and after implementing this policy; there should be some follow-up and evaluation by surveying and interviewing patients to measure their satisfaction regarding the provided care.
Others suggested that the provision of spiritual care should be included in the job description of nurses and doctors. This was reflected by the response of one of the head nurses:

There is generally a lack of job description, a limited number of team members, a low job satisfaction, and inadequate salaries among team members. Therefore, before requesting from staff to provide spiritual care to their patients, policy makers should improve the environment that influences the ability of healthcare providers to provide spiritual care. After doing so, they should make a clear policy that states the provision of spiritual care in the job descriptions of nurses and doctors.

When a clear policy about the provision of health care will be a part of the job description, healthcare providers will be obligated to provide spiritual care as one of the healthcare providers stated: “If there is a clear policy that we should provide spiritual care and if it is to be part of the job description, then we will do it.”

As mentioned previously, there is no policy about spiritual care in Gaza and none about the role of healthcare providers in this area. For example, the words ‘spiritual’ and ‘spirituality’ were not mentioned at all in the code of nursing (Palestinian Council of Health, 1996). On the other hand, in most developed countries, there is a clear policy about the responsibility of healthcare providers, especially doctors and nurse, in regard to providing spiritual care. For example; in the United States, the Joint Commission on Accreditation for Health Care Organizations (JCAHCO) requires that patients’ spiritual beliefs, practices and needs be assessed and met by healthcare providers (Clark, Drain, & Malone, 2003). Other countries such as United Kingdom (National Association of Health Authorities and Trusts, 1996; Nursing and Midwifery Council, 2002; Department of Health, 2003; National Institute for Health and Clinical Excellence (NICE), 2004; Multi-Faith Group For Healthcare Chaplaincy, 2006), Scotland (Scottish Government 2009),
Norway (Norwegian Nursing Association, 2001), Malta (Malta Code of Ethics, 1997), and recently Israel (Bentur, Resnitzky, Sterne, 2010) also include the provision of spiritual care in their codes of practice. For example, the Scottish National Health Care system took a further step by adopting a clear policy that requires all healthcare professionals to provide spiritual care to their clients (Chisholm 2002).

The involvement of the health policy makers and regulatory bodies in setting clear policies and regulations pertaining to the provision of spiritual care policy was not unique to the participants of this study. In a study conducted by McSherry and Jamieson (2010) that involved 4,054 nurses, the great majority (88.8%) of participants agreed on a statement that the regulatory body in the UK should provide them with clear guidelines regarding spiritual care and incorporating issues of spirituality in its culture and philosophy. Furthermore, the results suggested that participants needed clearer support and guidance from their unions to help them in dealing with matters related to spirituality.

Therefore, the adoption of a clear policy that mandates the provision of spiritual care by healthcare providers and including it in their job descriptions may help in providing spiritual care to hospitalized patients, including cardiac patients.

In accordance with what the healthcare provider participants suggested about implementing a spiritual care policy and then evaluating its outcome and cardiac patients’ satisfaction, Lemmer (2002) and Clark et al. (2003) emphasized the importance of tracking the implementation of providing spiritual care to patients to ensure its efficacy. Furthermore, they advised that spiritual care be benchmarked at the national level.
Beside the actions to be taken by health policy makers, healthcare providers suggested that some actions be taken at the organizational level. Those actions included providing in-service education and training for healthcare providers about how to provide spiritual care to all patients in general and to cardiac patients in particular. One of the doctors said:

The issue of providing spiritual care to cardiac patients is very important and we lack the skills for how to provide such care to our clients. I hope that the hospital can offer us some lectures about this topic and provide special courses to healthcare providers and train them about how to provide spiritual care. Also, I hope that they can give us some handouts about this topic.

Another head nurse confirmed the same idea and thought that giving staff some incentives would encourage them to provide spiritual care:

I think that the hospital needs to offer special training courses for healthcare providers, especially nurses, and to provide us with some books and journals that are related to the topic to help staff to review the topic, which will promote spiritual growth of the staff members. Finally, I think that giving some incentives for staff will encourage them to be more involved in providing spiritual care for their patients. This may encourage other staff to do the same.

Other participant added that the hospital needs to make some related books and journals available to the staff to increase their knowledge about spiritual care.

Furthermore, some added that it will be great if the hospital could provide some electronic means that could help in promoting the spirituality of cardiac patients:

They [the hospital] need to provide related books in the library. This will help us to read more about the topic. I also think that it will be great if they can provide each bed with head phones that are connected to a radio station that recites Quran. This will help cardiac patients to be connected to ALLAH and will help develop their spirituality.
Finally, some participants from among the healthcare providers suggested that the hospital should increase the number of staff working in the CCU and to be selective about choosing who will work at the CCU. They think that increasing the number of staff will decrease the work load on them, and thus will give them more free time to be involved in offering spiritual care to their clients. In addition, another participant suggested that the hospital should be more selective about choosing who is to work at the CCU:

I think that they need to be selective in assigning staff to work in the CCU. Not just anyone can work at the CCU. Assigned staff should be committed to their work and have special personal characteristics that enable them to communicate effectively with and influence patients.

The propositions made by healthcare provider participants were congruent with the literature. For example, Murray et al. (2003) concluded that general practitioners needed more training, especially about how to identify patients’ spiritual needs, how to use spiritual assessment tools, and how to intervene to resolve spiritual distress. Silverman, Kurtz, and Draper (2004) added that healthcare providers need intensive teaching and training about effective patient-centered communication in order to be able to detect patients’ spiritual needs and then be able to provide spiritual care.

Another issue that was raised by participants in this study and corresponded with the literature is the need to increase the number of staff. That will help in providing enough time for providing spiritual care for their clients. General practitioners in the study by Murray et al. (2003) felt that lack of time was one of the major constraints on providing spiritual care. One of the general practitioners in their study mentioned that if
they “spend three-quarters of an hour with one patient; you’re spending 5 minutes with the other three” (Murray et al. 2003, p. 958).

Including Spirituality in Health Education (Formal and Informal)

Another theme that emerged from the healthcare providers’ responses pertained to the inclusion of spiritual care in the formal education of healthcare professionals. Both physicians and nurses mentioned that their formal education lacked spiritual care and therefore they strongly advised that spirituality and spiritual care be included in the curricula of health education for physicians, nurses, and other healthcare professionals. Some of the participants suggested that spirituality and spiritual care should be included in the curriculum as an elective course:

Spirituality should be included in the curriculum of healthcare education and I suggest that it should be a part of the elective courses. The course itself would include a theoretical part and a practical part that will help to train future healthcare providers to provide spiritual care to their clients.

Another participant (head nurse) emphasized the need to include spiritual care in the curriculum of health education and noted:

Offering spiritual care to cardiac patients and other patients is very important. Therefore, I think that health education should include spiritual care in the curriculum by offering it in a special course or involving it in other courses. They [health educators] need to prepare students to provide spiritual care and to prepare them in how to communicate properly with their patients.

Another head nurse confirmed that health education should embrace spirituality and spiritual care and it should deal with it from an Islamic perceptive, since the greater majority of the population in Gaza Strip are Muslims:
I think that there should be a special course that addresses providing spiritual care from an Islamic viewpoint. It should include training healthcare providers about how to offer such care. The theoretical part is important, but I would like to mention here that all of our work is practical.

From a different perspective, one of the participants suggested that the Ministry of Health should have some influence on the curricula of local health education and to coordinate with local health education institutions to include spirituality and spiritual care in the formal health education:

I suggest that the Ministry of Health should have influence on the health education. This can take place by coordination between the Ministry of Health and the Ministry of Higher Education. The Ministry of Health should require from the Ministry of Higher Education that the curriculum of health education should include this important part of care.

These suggestions were about including spirituality and spiritual care in the formal education for future healthcare professionals. But others suggested that some in-service education and training to be offered to healthcare providers: “Spiritual care should be included in in-service education of each organization. There should be some training courses for all staff members about how to provide spiritual care to their patients.”

Inadequate education was reported by participants and is noted in the literature (Orchard, 2000; Feudtner, Haney & Dimmers, 2003; Fletcher, 2004; Pronk, 2005; Kliwer & Saultz, 2006, Van Leeuwen, Tiesinga, Post, & Jochemsen, 2006; Chan, 2009, McSherry & Jamieson, 2011) as one of the major barriers for providing spiritual care. Therefore, including spiritual care teaching and training in the curricula of health education may help in equipping future healthcare providers with needed skills to assess spiritual needs of their clients and to provide spiritual care to them. This was evident in
the responses of the healthcare providers participated in this study. Similarly, the issue of including spirituality and spiritual care in the health education was strongly emphasized in the literature (Bradshaw, 1997; Meyer, 2002; Vance, 2001; Olsen et al., 2003; and Hessig et al., 2004) as a means for potential solution, since this will prepare and train future healthcare providers to be better able to assess and meet the spiritual needs of their clients. For example, the greater majority of participants in McSherry’s and Jamieson (2011) agreed that spirituality and spiritual care should be addressed in education programs for nurses and they, along with participants of Ross (1996) and Narayanasamy (1993), welcomed further education on spirituality and spiritual care. Similarly, Murray et al. (2003) reported that general practitioners needed training about assessing and meeting the spiritual needs of their clients.

Furthermore, more direct and explicit approaches of teaching spiritual care for healthcare providers in general and nurses in particular were introduced by Narayanasamy (1998), McSherry and Draper (1997) and Ross (1996). McSherry and Draper (1997) identified several factors -- internal (political, socioeconomic, managerial or educational) as well as external (social, cultural and religious) -- that may impede the full integration of the spiritual dimensions in nursing curricula. Thus, some kind of changes and modifications should be introduced to the nursing curricula in order to integrate spirituality within the nursing educational programs. Similarly, Narayanasamy (1993) and Ross (1996) offered research verification suggesting that nursing education scope needs to be more comprehensive in its approach by amalgamating spirituality as a subject into its curriculum. Narayanasamy (1999) suggested the ASSET model (Actioning Spirituality and Spiritual Care in Education and Training for Nursing) as a
clear direction for delivering spiritual care education. The model is structured on self-awareness, spirituality, and the spiritual dimension of nursing, and built upon the nursing process that includes assessment, planning, implementation and evaluation. A major advantage of this model is that it is flexible, and offers “salient features related teaching and learning spirituality” (Narayanasamy, 1999, p.275). Finally, McSherry, Gretton, Draper, & Watson (2008) affirmed the importance of the role of education in preparing nurses to be aware of spirituality, its components and barriers to providing spiritual care. Consequently, Mcsherry et al. thought that there is a need to assess the level of the nurse’s comprehension regarding spirituality and spiritual care concepts when tailoring spiritual care education.

Similarly, some advocate including spirituality and spiritual care in the health education of physicians. For example, in the United Kingdom, due to efforts of some advocacy groups at the Royal College of Psychiatrists, several medical schools adopted the inclusion of spirituality in medical education (Williams, 2008). Along similar lines, the awareness of spirituality among medical educators has been increasing markedly in the United States. Therefore, medical schools have begun to include some courses related to spirituality and religion and their impact on health. According to Levin, Larson, Puchalski (1997), about 30 medical schools were offering these courses by the mid-1990s. In fact, according to Puchalski (2002), the number of medical schools teaching spirituality courses has increased significantly in recent years in response to the call of the Association of American Medical Colleges (AAMC) for the establishment of learning objectives and methodology for teaching courses on spirituality, cultural issues and end-of-life care.
Miscellaneous Interventions

Besides the above suggestions made by the healthcare provider participants, there were some other miscellaneous suggestions that did not fit into a unified theme. Some of these suggestions included educating the public about the importance of spiritual care for patients and its effect on their health. This could be approached through the use of the media, Internet, radio, and the distribution of handouts:

I think that we [healthcare providers] should make more efforts to educate the public, including the healthcare policy makers, about the importance of spiritual care and its effect on health. We can use the media, websites, and handouts to educate the public about the importance of providing spiritual care, not only to cardiac patients, but also to other kinds of patients.

Another participant suggested including an Imam (Muslim clergyman) in the health care team. The only job he should do is providing spiritual care for patients in who are in need. Another participant suggested that some coordination between the Ministry of Health and the Ministry of Religion to assign some Imams to schedule regular visits to the hospitals in order to provide spiritual care for hospitalized patients:

There should be a cooperation between the Ministry of Health and the Ministry of Religions so that some Imams from the Ministry of Religion can visit the patients periodically and help in providing spiritual care to patients.

Finally, one of the participants suggested that the nursing team include a senior nurse who has the experience in providing spiritual care, to be present in each shift. He/she can provide spiritual care to patients and can serve as a mentor for other younger nurses.

The team should include a senior nurse who has enough experience. This nurse should be assigned minimal physical tasks so that he/she can dedicate most of
his/her time to providing spiritual care to the patients. Other younger nurses can learn from that nurse how to provide spiritual care.

The presence of a clergymen or a chaplain in the health care team is well recognized in the literature (Levin, Larson, & Puchalski, 1997; Vande Creek, 1997; Vande Creek & Lyon, 1997; Sloan, Bagiella & Powell, 1999; Koenig, Fitchett, Meyer & Burton, 2000; Orchard, 2000; Post, Puchalski, & Larson, 2000; Astrow, Puchalski & Sulmasy, 2001; Koenig, 2002; Lo, et al., 2002; Puchalski, 2002; Clark, Drain & Malone, 2003; Feudtner, Haney & Dimmers, 2003; Handzo & Koenig, 2004; Narayanasamy et al., 2004; Baldacchino, 2005; Galek, Flannelly, Vane & Galek, 2005; Pronk, 2005; Chan, 2008; Timmins & Kelly, 2008; and Rufener, 2011), which is consistent with the results of this study. For example, Clark, Drain, and Malone (2003) called for building a 'quality improvement team' that consists of multidisciplinary healthcare professionals including a clergymen. They further claimed that the presence of a religious person on the healthcare team will serve many patients who are in emotional and spiritual crisis. A similar suggestion was made by one of the respondent to establish a committee for "Spiritual Care" similar to "Infection Control" committees.

Narayanasamy & Owens (2001); Narayanasamy, Gates & Swinton (2002); and Clark et al. (2003) agreed with the results of this study about the importance of having experience in providing spiritual care. Clark et al. recommended the presence of an experienced nurse in the team at each shift. They claimed that the presence of senior leadership will help to empower other team members to maximize support to other staff; which will lead to reducing time in implementation of some procedures; it can facilitate cooperation between physicians, nurses, chaplains and other hospital staff. Such
cooperation will make more time available for staff members to provide spiritual care for their clients. Similarly, Carroll (2001) made the connection between experience and the capacity to offer adequate spiritual care. Furthermore, Lemmer (2002) suggested the need to identify nurses who are expert in providing spiritual care and use their experience in providing such care for patients who are in need.

Ross (1994) and Kuuppelomaki (2001) added that communication and good links with other members of the health team will maximize benefits for patients in regard to meeting emotional and spiritual needs.

Summary

A total of 279 cardiac patients who were admitted to the CCUs in Gaza Strip hospitals and 12 healthcare providers participated in this study. The data collection included a quantitative part and a qualitative part. Cardiac patient participants reported that they received minimal spiritual care from their healthcare providers during their hospitalization period. These results were consistent with the literature. When they asked about their preferences about who should provide spiritual care, the majority reported that they preferred nurses to provide spiritual care to them. When the same question was asked of healthcare participants, there was some controversy in their responses, but nurses were ranked first. This controversy was mirrored in the literature, where many articles touch on this topic.

The analysis of the qualitative part of the study, which included data collection from healthcare providers, focused on answering three main questions: who should
provide spiritual care, what are the barriers and challenges they face in providing spiritual care to their clients, and how these barriers be overcome?

The responses of healthcare providers as to the barriers for providing spiritual care were categorized into several themes. These included inadequate education and training, ambiguity about spirituality, inadequate time, shortage of staff, policy-related barriers, and individual-related barriers. Most of the barriers reported by the health care participants were reported in the literature.

To overcome these barriers, healthcare professionals suggested several strategies that were grouped into the following thematic categories: policy change, organizational interventions, including spirituality in health education (formal and informal) and other miscellaneous interventions. These strategies were also reported in the literature.
CHAPTER V
CONCLUSIONS AND FUTURE DIRECTIONS

This chapter summarizes the findings of the study. It includes the answers for the research questions posed. Limitations of the study are discussed. Implications and recommendations for improving the delivery of spiritual care for cardiac patients and other patients are discussed. Furthermore, several recommendations for future studies are also outlined. Finally, general recommendations are offered.

Summary of the Study

According to the Ministry of Health, heart disease is the leading cause of death among the Palestinian people (Palestinian Health Information Center, 2010 & Ministry of Health-Gaza: Health Information Center, 2011). Cardiac patients are at higher risk for a more endangered life and delayed recovery from heart attacks when they experience stress (Harvard Men’s Health Watch, 2006). This renders them more liable to the possibility of repeated hospitalization. Since the incidence of heart disease is usually associated with stress (Timby, 2009), prevention and relief of stress become a major concern for patients with heart disease (Oates, 2004). One of the approaches to reduce stress is the provision of spiritual care. According to Mytok & Knight (1999), spiritual beliefs function as a protector against stressful physical and
emotional events associated with chronic illnesses including heart failure and other cardiac diseases. Furthermore, at the clinical level, several studies emphasized that spirituality is associated with decreased anxiety and depression and increased capabilities in emotional coping (Mickley & Soeken, 1993; Tuck, 2001; Thoresen & Harris, 2002).

Healthcare professionals strive to provide holistic care for their clients to meet the WHO definition of health, which clearly included a spiritual component of health (WHO, 1998). Despite such assertions about the importance of including emotional and spiritual needs in patient care, there is evidence in the literature that healthcare professionals focus on meeting the physical, social and psychological needs of their patients and seldom recognize their spiritual needs (Piles, 1990). For the most part, spiritual needs of patients are often neglected or underestimated (Forbes, 1994, Camp, 1996). Recently, more attention has been paid to spiritual care and it has increasingly attracted the attention of researchers, healthcare professionals and educators over the past three decades (Murray et al., 2004). The relationship between spirituality and illness is at the core of a growing body of literature (Kaey & Raghavan, 2002). As a result, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recognized that patients’ “psychosocial, spiritual and cultural values affect how they respond to their care” (Joint Commission Resources, 2003, p. RI-8) and has concentrated on spirituality and emotional wellbeing 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 (Gray et al., 1994).
Although spiritual care is considered an important aspect of health care, there are no agreements about who should and would be able to offer spiritual care within the health care system. Although most hospitals in Western countries assign chaplains and pastoral teams to address the emotional and spiritual needs of the patients; nurses, physicians, clinicians, and other health caregivers can play equally important roles (Clark et al., 2003). However, in Gaza Strip, such services are not available. Almost no formal spiritual care is provided at the hospitals or other healthcare facilities.

In spite of the great number of studies about spirituality and spiritual care for cardiac patients and patients with other diseases, there is scanty literature on spiritual care for cardiac patients in developing countries, including Muslim countries. Furthermore, there are no studies that were conducted in Gaza Strip to investigate whether spiritual care is offered to cardiac patients or not, who should provide spiritual care to cardiac patients, to investigate the barriers to offering spiritual care, or to explore possible interventions to overcome barriers that impede offering spiritual care for cardiac patients living in Gaza Strip. Therefore, this study aimed to assess whether spiritual care is being provided to hospitalized cardiac patients who live in Gaza Strip, to explore who should provide spiritual care, to identify the barriers for providing such care, and to examine how these barriers might be overcome.

In order to assess if spiritual care is provided by healthcare professionals to cardiac patient in Gaza Strip, an instrument developed and tested for reliability and validity by Musa (2007) was used. The instrument measures cardiac patient participants’ perceptions regarding the frequency of provision to them of spiritual
care and who in their view is the most appropriate person to provide spiritual care. A semi-structured interview was used to interview 12 healthcare providers as a tool to collect data about who should provide spiritual care to cardiac patients admitted to CCUs in Gaza Strip hospitals, to identify barriers that they face to provide spiritual care to their clients, and to explore possible means to overcome these barriers.

The design for the study used both qualitative and quantitative approaches in data collection. The quantitative data approach was used to collect data from cardiac patients. A total of 281 patients were recruited from the main three medical centers with CCUs in Gaza Strip. Of them, 279 patients agreed to participate in the study, a response rate of 99.29%. The qualitative data collection approach was used to collect data form healthcare provider participants. Twelve healthcare professionals who have managerial roles were recruited and all of them agreed to participate in the study.

The responses of the cardiac patients who participated in this study revealed that there is a severe shortage of spiritual care in both spiritual assessment and spiritual intervention domains. These results were consistent with the results of many studies that investigated healthcare professionals, patients, and patients and their caregivers about the adequacy of provision of spiritual care, and revealed that inadequate spiritual care was provided by healthcare professionals (Taylor et al., 1995; Dixon et al., 2000; Kuuppelomäki, 2001; Stranahan, 2001; Clark et al., 2003; Feudtner et al., 2003; Taylor & Mamier, 2005; Musa, 2007; McSherry and Jamieson, 2010).

When both groups of participants were asked about who should provide spiritual care to cardiac patients, the majority of the cardiac patients (n=159, 57%)
reported that they preferred nurses to provide spiritual care to them. When the same question was asked to healthcare provider participants, there was some controversy in their responses, but nurses were ranked first by five participants, and four participants agreed that the provision of spiritual care should not be monopolized by a specific profession, but rather should be the work of the entire health care team.

These results were consistent with the literature, as many studies reported several professionals and non-professionals as the most resourceful persons to administer spiritual care and spiritual support to patients. The list included nurses along with family members, physicians, friends, and clergymen (Reed, 1991; Highfield, 1992; Camp, 1996; Ross, 1998; Taylor, 2002; Handzo & Koenig, 2004; Pronk, 2005; Sawatzky & Pesut, 2005; Taylor, 2005; Baldacchino, 2006; Musa, 2007).

The analysis of the qualitative part, which included data collection from healthcare providers, focused on answering three main questions: who should provide spiritual care, what are the barriers and challenges they face in providing spiritual care to their clients and how can these barriers can be overcome?

The responses of the healthcare providers as to the barriers they face to provide spiritual care were grouped into several thematic categories. These themes included inadequate education and training, ambiguity about spirituality, inadequate time, shortage of staff, policy-related barriers, and individual-related barriers. Most of the barriers reported by the healthcare participants were also reported in the literature.

To overcome these barriers, healthcare providers suggested several strategies that were grouped into the following thematic categories: policy change,
organizational interventions, including spirituality in health education (formal and informal) and miscellaneous interventions such as educating the public about the importance of spiritual care, including an Imam (Muslim clergyman) in the health care team to provide spiritual care for patients, and assigning a senior nurse who has the experience in providing spiritual care to be available at each shift. These strategies suggested by the healthcare providers were consistent with the literature.

Limitations of the Study

Much like other studies, this endeavor has its own limitations which need to be considered. First, the lack of available statistics about the actual numbers of patients diagnosed with heart disease in Gaza Strip was one of the most important limitations for this study. It had an impact on calculating an accurate sample size for this study. As a consequence, the researcher had to use a convenience sample for this study, which affects the generalizability of the results. Second, in spite of the fact that there is ample literature available about spirituality and spiritual care; the great majority of these studies were conducted in developed countries, where the majority of its population was Christians. Only one study was identified that was conducted in a developing Muslim country, namely in Jordan in research by Musa (2007). This evident lack of literature in similar communities that share some key characteristics with the Palestinian community did not allow the researcher to compare her results with similar studies.
Another limitation for this study was that the sample was a homogenous one, since all cardiac patient participants had the same religion, same ethnic background, same language, and relatively similar social backgrounds. As a result, the findings of this study cannot be generalized to other cardiac patients who had different religious and ethnic backgrounds.

The concept of spirituality was an unfamiliar concept to both groups of participants of this study, i.e. the healthcare providers and cardiac patients. This was evident in the answers given by the healthcare providers participating in the study, especially when they were asked to define spirituality and spiritual care. Cardiac patients were also unaware of their rights to receive spiritual care and were astonished when the questionnaire was delivered to them, since they were not expecting that spiritual care could be considered a part of health care.

Inadequate knowledge among cardiac patients and several healthcare provider participants about the topic of spirituality could be considered as a limitation to this study. The researcher thinks that if participants from both groups had a stronger base of knowledge about the topic, they would provide responses and answers that have more depth, which would add to the depth of the study.

A final limitation to this study was that the semi-structured interview for the qualitative part of data collection was conducted in Arabic. When the data was analyzed, it was hard for the researcher at various points to translate the responses into the English language because some Arabic expressions had no synonyms in English. As a consequence, the researcher had to use the best English words that could yield the closest possible meaning of the concepts. This was evident as a
problem when the researcher analyzed this part of the study and was trying to extract the themes for the qualitative part of this study.

Answers to Research Questions

This study was designed to answer four main questions: (1) according to the cardiac patients admitted to the cardiac care units (CCUs) in Gaza Strip hospitals, to what extent spiritual needs are addressed? (2) To whom should the burden of providing spiritual care to cardiac patients admitted to CCUs in Gaza Strip hospitals be left? (3) What are the administrative/organizational barriers to providing spiritual care to cardiac patients admitted to CCUs in Gaza Strip hospitals? And (4) What can be done to remove barriers to providing spiritual care and increasing the frequency of providing spiritual care for cardiac patients admitted to CC’s in Gaza Strip hospitals?

Research Question # 1: According to the Cardiac Patients Admitted to the Cardiac Care Units (CCUs) in Gaza Strip’s Hospitals; to What Extent Spiritual Needs Are Addressed?

Cardiac patients’ perceptions about the frequency of providing spiritual care by healthcare providers were measured by the Spiritual Care Rating Scale, (domain frequency) (SCRS-F), which was developed by Musa (2007). The SCRS-F contains 39 items and was divided by Musa into two major subscales: Spiritual Care Assessment Rating Scale, which assessed the frequency of providing spiritual care
assessment by healthcare providers, and Spiritual Care Intervention Rating Scale, which assessed the frequency of spiritual care interventions provided by healthcare providers.

Findings based on the cardiac patients’ responses revealed that there is a severe lack of spiritual care furnished to them by healthcare providers. For example, the responses of the cardiac patients concerning the items of the Spiritual Care Assessment Rating Scale items (items 1-18) revealed that spiritual assessment was rarely performed by healthcare providers (responses of “absolutely not conducting spiritual assessment” ranged between 82.15% and 98.9% with the majority of responses {14 items out of 18} were more than 90.7%) [table 4-8].

The responses of cardiac patients to the items of Spiritual Care Intervention Rating Scale (items 19-39), presented in table 4-9, showed great variances. For example, participants’ responses indicating that spiritual care was “absolutely not” offered to them ranged from 12.9% to 93.9% with the majority of them ≥ 62.4 (11 items out of 20).

To better explain the results, the responses of cardiac patients were converted into scores according to the following: ‘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 were calculated and presented in tables 4-10 and 4-11. Then the mean of the items of the Spiritual Care Assessment Rating Scale, Spiritual Care Intervention Rating Scales, and for all items of the instrument, were calculated and presented in table 4-12. The mean for providing spiritual care assessment items (items 1-18) was
2.58 and standard deviation 5.576 (table 4-10). The mean for providing spiritual care intervention items (items 19-39) was 24.68 and standard deviation of 12.134. Finally, the mean for both Assessment and Intervention Scales was 14.54 (standard deviation 7.573). Such very low scores reflect the severe deficiency in providing spiritual care by healthcare providers to cardiac patients admitted to CCUs in Gaza Strip.

The results of this study were consistent with the results of many studies. Numerous investigations have been designed and conducted to explore the adequacy of providing spiritual care to different groups of patients, such as cancer patients and patients diagnosed with heart disease (Taylor et al., 1995; Dixon et al., 2000; Kuuppelomäki, 2001; Stranahan, 2001; Clark et al., 2003; Feudtner et al., 2003; Taylor & Mamier, 2005; Musa, 2007; McSherry and Jamieson, 2010). Some of these studies targeted the perception of patients themselves, others targeted the patients and their caregivers, and some targeted healthcare providers. Regardless of the group of participants targeted, it was reported by all of these studies that spiritual care provided was inadequate.

Research Question # 2: To Whom Should the Burden of Providing Spiritual Care to Cardiac Patients Admitted to CCUs in Gaza Strip’s Hospitals Be Left?

This question was asked of both groups of participants: cardiac patients and healthcare providers. The responses of both groups varied about who should provide spiritual care. The majority of cardiac patient participants (n=159, 57%) thought that nurses were the most appropriate persons to provide spiritual care to them, followed
by family members (n=72, 25.8%). Only six participants (2.2%) preferred physicians to provide spiritual care to them (Table 4-13).

When the same question was asked put to healthcare providers, their responses varied. Five participants (all with nursing backgrounds) responded that nurses usually spend more time with the patients; therefore, they should provide spiritual care to their patients. Other healthcare providers responded that spiritual care should be provided by a doctor, a psychologist or a social worker. Finally, four of the participants agreed that the provision of spiritual care should not be monopolized by a specific profession, but should be the work of the entire health care team.

The variances of participants’ answers in response to this question mirrored the variation reported in the literature about who should provide spiritual care. The literature reported reference to many professionals and non-professionals as the most resourceful persons to patients with spiritual care and spiritual support. The list included nurses along with family members, physicians, friends, and clergymen (Reed, 1991; Highfield, 1992; Camp, 1996; Ross, 1998; Taylor, 2002; Handzo & Koenig, 2004; Pronk, 2005; Sawatzky & Pesut, 2005; Taylor, 2005; Baldacchino, 2006; Musa, 2007). The majority of these studies did not rank the preference of patients regarding who is the most resourceful person for spiritual support, with few exceptions. For example, Musa (2007) reported that nurses were ranked as the most resourceful person for spiritual support according to cardiac patients’ perceptions, which is consistent with the results of the present study. On the other hand, in Reed’s (1991) study, nurses ranked behind family members, friends, and clergy. In several studies (Highfield, 1992 and King & Bushwick, 1994), physicians came as the first
choice of participants for the most resourceful persons for potential spiritual support, a finding which is inconsistent with the results of this study.

Research Question # 3: What Are the Administrative/Organizational Barriers to Providing Spiritual Care to Cardiac Patients Admitted to CCUs in Gaza Strip’s Hospitals?

Analysis of the qualitative part for the responses of healthcare providers participating in the study in regard to the barriers to providing spiritual care for cardiac care patients revealed the presence of several barriers. The emerging barriers were coded and grouped into the following thematic categories: inadequate education and training, ambiguity about spirituality, inadequate time, shortage of staff, policy-related barriers, and individual-related barriers.

Inadequate Education and Training

Results of data analysis showed that there was a very little, if any, formal or non-formal education that covered the topic of providing spiritual care. All healthcare provider participants mentioned that they did not receive any formal education about spiritual care, with the exception of one participant (one of the head nurses) who mentioned that the topic was touched on slightly during his bachelor degree studies. Furthermore, two participants (medical directors) mentioned that they never heard about spirituality and spiritual care. The concepts of spirituality and spiritual care
were not clearly included in their health education. Rarely were these terms as such broached in health education. Only a few health educators dealt with the topic during some courses, especially those including some discussion of ethics, and that was usually related to personal interest on the part of those educators and was not a part of the actual syllabus. The issue of spirituality and spiritual care was likewise not included in the in-service education arranged by the hospitals. Several participants mentioned that spirituality and spiritual care were touched on marginally in a few sessions dealing with in-service education for palliative care.

In spite of the absence of formal education on spiritual care, some participants obtained a certain amount of knowledge about spirituality from religious speeches at the mosques, from media, and from surfing the Internet. Other participants mentioned that through their practical experience and through personal interest, they gained some clues about the importance of providing spiritual care and about how to provide spiritual care to their clients.

The results of this study are congruent with many studies that reported on the lack of education and training regarding spiritual care in health education (Orchard, 2000; Feudtner, Haney & Dimmers, 2003; Fletcher, 2004; Pronk, 2005; Kliewer & Saultz, 2006; Van Leeuwen, Tiesinga, Post & Jochemsen, 2006; Chan, 2009; McSherry & Jamieson, 2011). For example, nurses participating in studies conducted by McSherry (1997), McSherry & Jamieson (2011), and Stranhan (2001) reported that they did not receive enough educational preparation and training to meet their patients’ spiritual needs. Furthermore, Murray et al. (2003) added that general
practitioners needed some support and training to help them in identifying spiritual needs and providing appropriate spiritual interventions to their clients.

While some studies revealed lack of education and training of healthcare providers in regard to spirituality, other studies (Greenstreet, 1999; Shih, Gau, Mao, Chen & Lo, 2001; Chung, Wong, & Chan, 2007) showed that teaching spirituality is essential in health education and will have an impact on clinical practice. Others added that absence or inadequate inclusion of spirituality in health education curricula may lead to poor and improper provision of spiritual care (Dover & Bacon, 2001; McSherry, 2006, Ross, 2006; Van Leeuwen, 2006).

Ambiguity about Spirituality

The concept of spirituality was not clear to most of the health care providers participating in this study, since the researcher established that it was very difficult for them to define spirituality, and some were unable to define it. For those who tried to define spirituality, it was obvious that there was no common agreement in their responses about what spirituality and spiritual care are. In general, it was noticed that all participants, when trying to define spirituality, connected it to ALLAH (God) and religion. Furthermore, one participant described it as “a branch of medicine that produces unreliable results.”

These results were consistent with the literature, since many researchers and other authors reported on the vagueness and ambiguity of spirituality and how difficult it is to define it, since a person is attempting to define something that is
intangible and mystical (Reed, 1992; Macrae, 1995; Clark, 1997; Greasley, Chiu, Gartland, 2001; Lemmer, 2005; Sawatzky & Pesut, 2005). On the other hand, (Narayanasamy, et al., 2004) mentioned that several scholars in spirituality noted that spirituality is an elusive concept when they try to define it. Furthermore, the ambiguity about spirituality is evident in the numerous different definitions available in the literature. Deborah Rufener (2011, p.5) commented on this abundance of definitions in the literature, noting that “the varying content of these definitions can be a source of confusion to nurses as they address components of assessment, intervention, and evaluation of spirituality. The term may be defined differently between nurses, between nurse and patient, between nurse and family, as well as between the patient and their loved ones.”

As was mentioned earlier, when healthcare providers participating in this study tried to define spirituality, almost all of them linked it with religion. These responses are congruent with many studies and definitions that perceived the premise of spirituality as a term synonymous with ‘religion,’ and generally both terms can be used interchangeably (Taylor, Amenta & Highfield, 1995; McSherry, 1998; McBrien, 2010; Carroll, 2001; Narayanasamy & Owens, 2001; Stranahan, 2001; Swinton, 2001). In fact, in several studies (Harrison and Burnard, 1993; Narayanasamy, 1993; Ross, 1997; Bruce 1998), it was noticed that nurses were confused and regarded spirituality as religion. McSherry & Jamieson (2011) added that some of the healthcare professionals are uncertain about distinguishing between religious and spiritual care.
**Inadequate Time**

Inadequate time was one of the barriers reported by healthcare providers that hindered the provision of spiritual care to cardiac patients admitted to CCUs in Gaza Strip hospitals. Healthcare providers are relatively busy caring for critically ill patients in particular. There is an inadequate number of CCU beds, a fact which necessitates early pre-mature discharge of some patients.

This reported barrier is consistent with the literature, as many scholars and researchers, especially in the field of nursing, reported that inadequate time was one of barriers for providing spiritual care for patients (Orchard, 2000; Carroll, 2001; Dover and Bacon, 2001; Kuuppelomaèki, 2001; Lemmer, 2005; Kliewer & Saultz, 2006; Van Leeuwen, Tiesinga, Post, & Jochemsen, 2006; Williams, 2008; Chan, 2009). Time was also reported as a barrier to providing spiritual care by general practitioners (Murray et al 2003) and physicians (Koeing, 2004). Williams (2008) added that time constraints will affect the energy of staff and as a consequence, healthcare providers will not be “attentive to deeper dimensions of patients’ concern” (p. 4), including their spiritual needs.

Although half of the healthcare provider participants mentioned that they could not provide spiritual care to cardiac patients due to a lack of time, some of them disagreed and said that there is no need to set a specific time to provide spiritual care. Spiritual care can be provided simultaneously while doing other physical tasks. Williams (2008) agreed with these participants, since some research findings reported that certain personal characteristics such as perceived ability and willingness to be
involved in providing spiritual care contribute to providing spiritual care, rather than negative time constraints. In the same vein, Grotbo (2000) added that healthcare providers can provide spiritual care while providing physical care.

**Shortage of Staff**

Another barrier to providing spiritual care according to healthcare providers was shortage of staff, including physicians and nurses. Other issues related to this barrier were rotation of staff and assigning new graduate nurses to work at the CCUs. The issue of shortage of staff as a barrier to providing spiritual care was commonly reported by nursing staff participants. According to participants, shortage of staff will make them overloaded with work and compel them to focus totally on providing essential care, including meeting the physical needs of their clients and ignoring their psychological and spiritual needs.

The results of this study are supported by the literature. Several researchers reported that lack of staffing was a barrier to providing spiritual care (Ross 1994; Harrington, 1995; McSherry, 1998; Carroll, 2001; Feudtner, Haney & Dimmers, 2003; McSherry, 2006; Chan, 2008). The literature did not only report the inadequate numbers of healthcare providers; Feudtner, et al. (2003) also reported that there was a shortage of pastoral staff.
Policy-Related Barriers

Another issue that was reported by the healthcare providers participating in the study as a barrier to providing spiritual care was related to the available health care policies and health policy decision makers. More than half of the healthcare providers participating mentioned that there are no clear policies about the inclusion of spiritual care in their job descriptions. Others pointed out that health policy-makers in Gaza Strip themselves are not aware of the importance of providing spiritual care to hospitalized patients.

The results of this part of the study contradict the literature in one area and agree with it in another. As was mentioned by healthcare providers, there is no policy about spiritual care and none about the role of healthcare providers in this area. This part contradicts the literature in most developed countries, where there is a clear policy about the responsibility of healthcare providers, especially doctors and nurses, in regard to provision of spiritual care. For example; in the United States, the Joint Commission on Accreditation for Health Care Organizations (JCAHCO) requires that patients’ spiritual beliefs, practices, and needs be assessed and met by healthcare providers (Clark, Drain, & Malone, 2003). Other countries such as United Kingdom (National Association of Health Authorities and Trusts, 1996; Nursing and Midwifery Council, 2002; Department of Health, 2003; National Institute for Health and Clinical Excellence (NICE), 2004; Multi-Faith Group For Healthcare Chaplaincy, 2006), Scotland (Scottish Government 2009), Norway (Norwegian Nursing Association,
2001), Malta (Malta Code of Ethics, 1997), and recently Israel (Bentur, Resnitzky, Sterne, 2010) also included the provision of spiritual care in their codes of practice.

In spite of the clear health policies about the role of healthcare providers related to provision of spiritual care and the acknowledgment of some healthcare providers about their role in providing spiritual care to their clients (Ross, 2006), many of the nurses interviewed by McSherry & Jamieson (2010) were uncertain about their role in providing spiritual care; some believed that it is not a nursing matter (Kuuppelomaèki, 2001). On the other hand, although doctors had clearly defined roles, including spiritual care, according to Williams (2003, p. 4) “spiritual care of patients is at best a secondary rather than a primary role.” Similarly, in spite of that, all general practitioners interviewed by Murray et al. (2003) recognized their role in provision of spiritual care to their terminally ill patients, but they were hesitant to do so, thinking that their patient might not raise this topic.

*Individual-Related Barriers*

Finally, the last barrier for providing spiritual care reported by healthcare providers was individual-related. For example, some healthcare providers pointed to an inadequate concept of spirituality, inadequate religiosity, lack of experience and communication skills as barriers to providing spiritual care.

The results of this study were consistent with other studies. For example, lack of experience was reported as a barrier to providing spiritual care by Orchard (2000) and Williams (2008). Lack of awareness among healthcare professionals about their
spirituality, including their beliefs and life experience, could interfere with their ability to provide spiritual care to their clients (Ross, 2006). Furthermore, Chan et al. (2006), Chung et al. (2007) and Chan (2009) found that nurses who had a high perception level about their own spirituality were more likely to provide spiritual care to their patients. Similarly, Stranahan (2001) found that the perception of nurses who felt that providing spiritual care is not essential to their patients had negatively influenced their practice in providing spiritual care. Kuuppelomaëki (2001) found that lack of religious conviction among healthcare providers and unfamiliarity with spirituality could contribute to inadequate provision of spiritual care to their patients.

Research Question # 4: What Can Be Done to Remove Barriers to Providing Spiritual Care and Increasing the Frequency of Providing Spiritual Care of Cardiac Patients Admitted to CCUs in Gaza Strip’s Hospitals?

Healthcare providers participating in this study made several suggestions to overcome the barriers and challenges that interfere with the provision of spiritual care for cardiac patients admitted to CCUs in Gaza Strip hospitals. These suggestions were categorized as follows: policy change, organizational interventions, including spirituality in health education (formal and informal), and miscellaneous interventions.
**Policy Change**

The majority of healthcare providers thought that health policy makers themselves are not aware of the importance of providing spiritual care to patients in general and to cardiac patients in particular. Therefore, they think that health policy makers need to be acquainted with research results that reflect the relationship between spiritual care provision and patients’ outcomes. Other suggestions included adoption of new policy mandating healthcare providers to provide spiritual care by the Ministry of Health, including provision of spiritual care in healthcare providers’ job descriptions, and following up and evaluating the implementation of this policy and its outcomes.

Absence of spiritual care policy from Gaza health care system is incongruent with the literature. The literature reveals that most of the developed countries have a clear policy about the responsibility of healthcare providers, especially doctors and nurses, related to providing spiritual care. Examples of countries that adopt a spiritual care policy include, but are not limited to, the United States (Clark, Drain, & Malone, 2003), UK (National Association of Health Authorities and Trusts, 1996; Nursing and Midwifery Council, 2002; Department of Health, 2003; National Institute for Health and Clinical Excellence (NICE), 2004; Multi-Faith Group For Healthcare Chaplaincy, 2006), Scotland (Chisholm 2002; Scottish Government 2009), Norway (Norwegian Nursing Association, 2001), Malta (Malta Code of Ethics, 1997), and recently Israel (Bentur, Resnitzky, Sterne, 2010).
The suggestion of involving health policy makers and regularity bodies in setting clear policies and regulations pertaining to the provision of spiritual care policy is congruent with the literature. For example, most of the nurses participating in McSherry’s and Jamieson (2010) study agreed on a statement that the regulatory body in the UK should provide them with clear guidelines regarding spiritual care and incorporating issues of spirituality in its culture and philosophy.

In accordance with what the healthcare providers participating in this study suggested, namely implementing a spiritual care policy and then evaluating its outcome and cardiac patients’ satisfaction, Lemmer (2002) and Clark et al. (2003) emphasized the importance of tracking the implementation of providing spiritual care to patients to ensure its efficacy. Furthermore, they advised benchmarking of spiritual care at the national level.

**Organizational Interventions**

Besides the actions to be taken by health policy makers, healthcare providers suggested that some actions be taken at the organizational level. Those actions included providing in-service education and training of current healthcare providers about how to provide spiritual care to all patients in general and to cardiac patients in particular. Other actions that could be undertaken to improve spiritual care to cardiac care patients related to supplying the libraries at the hospitals with some related books and journals to increase staff knowledge about spiritual care. Furthermore, some added that it would be excellent if the hospital could provide some electronic means
(such as headphones connected to Quran radio) that might help in promoting spirituality among cardiac patients. Other suggestions made by the participants that could be implemented by the administration included increasing the number of staff working in the CCUs and selectivity in choosing who will be hired to work at the CCUs. They think that increasing the number of staff will decrease the work load on them and will thus allow them more free time to be involved in offering spiritual care to their clients.

The suggestions made by healthcare provider participants were congruent with the literature. For example, Murray et al. (2003) concluded that general practitioners needed more training related to identify patients’ spiritual needs and how to intervene to resolve spiritual distress. Silverman et al. (2004) added that healthcare providers need intensive teaching and training about effective patient-centered communication in order to be able to detect patients’ spiritual needs and thus be able to meet these needs and provide spiritual care.

The suggestion to increase the number of staff was consistent with the literature. For example, general practitioners in Murray’s et al. (2003) study felt that lack of time was one of the major constraints on providing spiritual care. Therefore, increasing the number of staff would provide them with more time and opportunities to provide spiritual care to their patients.
Including Spirituality in Health Education (Formal and Informal)

Inclusion of spirituality and spiritual care in the formal health education for future healthcare providers is one of the means to improve the provision of spiritual care according to the healthcare providers, since their responses noted that their formal education was lacking in instruction on spiritual care and spirituality. For current healthcare professionals, they suggested providing them with some in-service education and training which would help them to administer spiritual care to their clients.

These suggestions to improve spiritual care to cardiac patients were consistent with the literature. The issue of including spirituality and spiritual care in health education was strongly emphasized in the literature as a means for a potential solution, because it would prepare and train future healthcare providers to be better able to assess and meet the spiritual needs of their clients (Narayanasamy, 1993, Ross, 1996; Bradshaw, 1997; McSherry and Draper, 1997; Narayanasamy, 1998; Vance, 2001; Meyer, 2002; Murray et al., 2003; Olsen et al., 2003; Hessig et al., 2004; Mcsherry et al., 2008; Williams, 2008; McSherry’s and Jamieson, 2011).

Miscellaneous Interventions

Other suggestions made by the healthcare providers participating in this study could not be fit into one consistent theme. Some of these suggestion included educating the public about the importance of spiritual care for patients and its effect
on their health. This could be approached through the use of the media, Internet, radio, and preparing and distributing handouts related to spirituality and spiritual care. Another suggestion was to include an Imam (Muslim clergyman) in the health care team to provide spiritual care for patients in need and some kind of cooperation to take place between the Ministry of Health and the Ministry of Religion to assign some Imams to schedule regular visits to the hospitals. A final suggestion was to assign a senior nurse who has the experience in providing spiritual care to work in each shift. He/she can provide spiritual care to patients and serve as a mentor for other younger nurses.

Most of these suggestions made by the healthcare providers participating in the study were congruent with the literature. For example, involving a clergyman or a chaplain in the health care team to provide spiritual care for patients who suffer from emotional and spiritual crisis is well recognized in the literature (Levin, Larson & Puchalski, 1997; Vande Creek, 1997; Vande Creek & Lyon, 1997; Sloan, Bagiella & Powell, 1999; Koenig, Fitchett, Meyer & Burton, 2000; Orchard, 2000; Post, Puchalski & Larson, 2000; Astrow, Puchalski & Sulmasy, 2001; Koenig, 2002; Lo, et al., 2002; Puchalski, 2002; Clark, Drain, & Malone, 2003; Cohent, 2003; Feudtner, Haney & Dimmers, 2003; Handzo & Koenig, 2004; Narayanasamy et al., 2004; Baldacchino, 2005; Galek, Flannelly, Vane, Galek, 2005; Pronk, 2005; Chan, 2008; Timmins & Kelly, 2008; and Rufener, 2011).

Narayanasamy & Owens 2001, Narayanasamy, Gates & Swinton, 2002, and Clark et al. (2003) agreed with the results of this study about the importance of having experience in providing spiritual care. According to Clark et al., the presence
of senior leadership will help to empower other team members and maximize support to other staff; this can lead to reducing time in the implementation of some procedures, and facilitate cooperation between physicians, nurses, chaplains, and other hospital staff. Such cooperation will make time more available for staff members to provide spiritual care for their clients. Similarly, Carroll (2001) made a link between experience and offering adequate spiritual care. Furthermore, Lemmer (2002) suggested identifying nurses who are experts in providing spiritual and then making use of their experience in providing such care for patients who are in need. Finally, Ross (1994) and Kuuppelomaki (2001) added that communication and good links with other members of the health team will maximize benefits for patients in regard to meeting emotional and spiritual needs.

Implications for Policy Change

Heart disease is one of the most common chronic diseases among Palestinians and it has been the leading cause of death over the last few years (Ministry of Health, 2005 & Palestinian Health Information Center, 2010). There are several approaches to treating heart disease, including medical and surgical interventions.

Because of the nature of their disease, cardiac patients are at higher risk for complications and delayed recovery when they experience stress, hostility, anger, depression, and social isolation (Harvard Men’s Health Watch, 2006). Therefore, they are more subject to possible repeated hospitalizations, which in turn will subject them to more stress and risk (Rieck, 2000). Besides the stress and anxiety due to the
disease they suffer from, hospitalized patients are vulnerable to other stressors such as pain and other physical discomfort, dependence, dealing with strangers and unknown caregivers, uncertainty, and invasion of privacy. Therefore, prevention and relief of suffering and alleviating stress become a major concern for cardiac patients (Oates, 2004).

With the increased number and magnitude of stressors, the number of patients diagnosed with heart diseases is growing (HF Commission, 2008). Furthermore, research results reported that stress was strongly associated with increasing the risk for myocardial infarction (Pratt et al., 1996) and increasing cardiac death and re-infarction (Denollet, 1997). Such increases in stressors and cardiac morbidity and mortality may necessitate the introduction of new types of treatment aiming at decreasing the impact of these stressors. One of the possible solutions that could be used conjunct with other traditional treatment regimens is to offer spiritual care. According to Mytok & Knight (1999), meeting the spiritual needs of patients, functions as a shield protecting against stressful physical and emotional events associated with chronic illnesses, including heart failure and other cardiac diseases. At the clinical level, several studies emphasized that spirituality is associated with decreased anxiety and depression (Mickley & Soeken, 1993; Thoresen & Harris, 2002). Furthermore, emotional comfort of spirituality was found to have a positive effect on a patient’s physical health (Kiecolt-glaser, Garner, Speicher, Penn, Holliday and Glaser, 1984 as cited by Clark, Drain, & Malone, 2003).

Based upon the results of several studies that clarified the impact of spiritual care on the health of patients in general and cardiac patients in particular, cardiac
patients deserve more attention from health care policy makers to improve their health condition, minimize their suffering, and upgrade their quality of life. The results of this study yielded several implications for policy change regarding spirituality and spiritual care for cardiac patients admitted to CCUs in Gaza Strip hospitals. The suggested health care policy areas include: adopting a spiritual care policy, health education policy, and initiating polices to overcome the barriers that halt the implementation of spiritual care.

Adopting a Spiritual Care Policy

The results of this study reported that there is no clear policy about providing spiritual care to cardiac patients admitted to CCUs in Gaza Strip hospitals and spiritual care was not mentioned in the job descriptions of the healthcare providers. As noted above, the words ‘spiritual’ and ‘spirituality’ were not mentioned at all in the code of nursing (Palestinian Council of Health, 1996). Therefore, it is suggested that the Ministry of Health should move to adopt the implementation of spiritual care policy in the system. The policy should clearly identify the responsibility of healthcare providers, especially doctors and nurses, in regard to providing spiritual care to their patients.

Spiritual care policy is incorporated in many health care systems such as in the United States (Clark et al., 2003), the United Kingdom (National Association of Health Authorities and Trusts, 1996; Nursing and Midwifery Council, 2002; Department of Health, 2003; National Institute for Health and Clinical Excellence
For example; in the United States, the Joint Commission on Accreditation for Health Care Organizations (JCAHCO) requires that patients’ spiritual beliefs, practices, and needs to be assessed and met by healthcare providers (Clark, Drain, & Malone, 2003). Implementing such a policy will contribute to providing spiritual care to cardiac patients, because such a policy will mandate health care providers to meet spiritual needs of their clients. When the spiritual needs of cardiac patients are met, this will help to reduce their stress, minimize their suffering, improve their health, enhance their quality of life, reduce the usage rates of both in-patient and out-patient health care services, decrease the frequency and length of their hospitalization and thus also decrease the costs of their treatment.

**Health Education Policy**

The results of this study revealed that the healthcare providers did not receive adequate education about spirituality and spiritual care during their formal education. Therefore, one of the most important policy implications of this study will relate to including spirituality and spiritual care in the curricula of health education in Gaza Strip at both theoretical and practical levels.

Hopefully, the results of this study, along with results of other similar studies, will help to enlighten health care policy makers and health education institutions.
about this topic and about the importance of spiritual care provision for the health of
different groups of patients. Such enlightenment could lead to embracing the concepts
of spirituality and spiritual care and involving them in health education in Gaza Strip.

Consequently, the researcher strongly recommends that workshops be
carried out on this topic. Besides professionals in health care education, other
professionals can be invited to these workshops. This includes professionals from the
Ministry of Health, nursing managers, medical directors of CCUs, in charge nurses of
CCUs, clinical instructors, clergymen, and officials from the Ministry of Religion.
Such workshops may come forward with several recommendations about including
spiritual care in health education for future healthcare providers.

Recommendations may include tailoring a special course that is exclusively
designed to address spirituality and spiritual care (which could be mandatory or an
elective course), or incorporating it into other courses. These courses should be
directed to help future healthcare professionals to assess and meet the spiritual needs
of their clients. In addition to emphasis on spiritual care in the classrooms, it should
be included in the clinical areas, addressed by clinical instructors.

These recommendations are in agreement with recommendations in the
broader literature. Reviewing the literature about health educational policy reflected a
growing attention to this aspect. For example, the American Association of Colleges
of Nursing (1986, p. 5) recommends that nursing education must ensure the nurses’
ability to comprehend the meaning of human spirituality in order to recognize the
relationships of beliefs to culture, behavior, health and healing and to plan and
implement this care. In the British context, British nursing education guidelines
require that nursing education undertake and document a comprehensive, systematic and accurate nursing assessment of physical, psychological, social and spiritual needs of patients, clients, and communities (UKCC 2000, p. 13).

The inclusion of spirituality in medical education is evident in the growing number of American medical schools teaching spirituality courses (Puchalski, 2002). Furthermore, the Association of American Medical Colleges (AAMC) called for the establishment of learning objectives and methodology for teaching courses on spirituality, cultural issues, and end-of-life care (Puchalski, 2002). On the other hand, the American Institute of Medicine lists spiritual wellbeing as one of six domains of quality supportive care of the dying patients (Field & Cassel, 1997), which could be applied to other patients, such as those diagnosed with heart diseases.

Therefore, health education policy makers should be encouraged to draft the guidelines for healthcare professionals’ (especially nurses and doctors) education focusing on the importance of spiritual care. In addition, the Ministry of Health can be expected to play a leading role in this matter and cooperate with the Ministry of Education and Higher Education in establishing a strategy for including spiritual care, its importance, methods for assessment, and its management in the curricula for future healthcare professionals.
Initiating Policies to Overcome the Barriers that Halt the Implementation of Spiritual Care

There were many barriers reported by healthcare providers the hindered the provision of spiritual care to cardiac patients admitted to the CC’s in the hospitals of Gaza Strip. Therefore, health policy makers need to consider these barriers and develop polices to overcome these barriers.

Increasing the Number of the Staff

Several health providers participating in this study reported that they did not have enough time to provide spiritual care to their clients. One of the reasons they mentioned for this was that there was an insufficient number of nurses and physicians. Such a shortage in the number of healthcare providers will require them perforce to focus mainly on meeting the physical needs of their clients and constrain them to put aside meeting other needs, such as the spiritual needs, that they consider less important. Based upon that, the researcher recommends that increasing the number of nurses and doctors and recruiting those who have more experience to be assigned to work in the CCUs will help to provide staff with more time which can be directed toward meeting the spiritual needs of cardiac patients admitted to Gaza Strip CCUs. Some could argue that increasing the number of staff will require some extra financial assistance. But recognizing that only three hospitals in Gaza Strip have CCUs, the number of extra staff will be a moderate financial burden. As an initial
step, hospitals could increase the number of nursing staff by one nurse in the morning and evening shifts, and one cardiologist at each hospital. Increasing the number of staff should not necessitate additional costs. Potentially and in the long-run, it may save money for the Ministry of Health, since providing spiritual care is expected to decrease the level of stress, anxiety, and pain of patients, which could be reflected in a concomitant reduction in the number of admissions, decreasing the length of their current hospitalization, and lowering the incidence of complications. The end result would in this scenario be reflected in a reduction in the total cost of the treatment for cardiac patients. Therefore, it is expected that the money saved would serve to cover the salaries of the new staff, if not more.

In-Service Education and Training of Current Staff

Many healthcare providers who participated in this study reported that they did not receive adequate education and training about providing spiritual care to their clients. While adopting spiritual care in health education will help to educate and train future healthcare providers, some actions need to be taken to educate and train current health providers to provide spiritual care to their clients. Therefore, it is imperative for the hospital administrations to arrange for in-service education aiming to educate current healthcare providers and to train them to provide spiritual care to their patients, especially those diagnosed with heart diseases.
Including a Clergyman (Imam) in the Health Care Team

The role of a clergyman or a chaplain in the health care team to provide spiritual care for patients who suffer from emotional and spiritual crisis is well recognized. According to Vande Creek & Lyon (1997), Hunt et al. (2003), and Kliewer & Saultz (2006), chaplains are the specialist professionals who can provide in-depth spiritual care to their patients, which will result in improved satisfaction and emotional comfort.

As the component of the health care team in the CCUs in hospitals in Gaza Strip does not include an Imam, it is recommended to add such a position to the health care team. Imams can collaborate with nurses and physicians and other staff in providing spiritual care to cardiac patients, relieving their stress and improving their emotional and spiritual wellbeing, which can be reflected in reducing the length of their stay in the hospital and decreasing treatment costs.

General Recommendations

Several recommendations came from this study. These recommendations pertain to the following areas: hospital administration, practice, public health policy, and public administration.
Recommendations for Hospital Administration

Since the findings of this study revealed a severe shortage in providing spiritual care to cardiac patients admitted to the CCUs in Gaza Strip, it is recommended that the hospital administrations do the following to facilitate the provision of spiritual care to cardiac patients:

1. It was noted that healthcare providers did not receive adequate education and training about spiritual care during their formal education. Therefore, it is recommended that the hospital administrations work on arranging some in-service education on spiritual care and train current healthcare professionals in methods of providing spiritual care to their clients.

2. Several healthcare providers reported that there was no or little literature about spirituality in the hospital libraries. Therefore, it is recommended that the libraries of the hospitals be supplied with several books, articles, and videotapes about spirituality and spiritual care. Making such literature readily available to healthcare providers will help them to read about the topic and practice what they learned from the literature for providing spiritual care to their clients. It is also recommended that some of these books be made available in a special mini-library at each CCU.

3. Some of the CCU’s do not have television receivers. It is recommended that TV sets be provided in all of the CCUs and that they be turned on to channels that broadcast religious programs and recite the Quran. It is also recommended that each bed be supplied with an overhead headphone so
that patients can listen to the television channels whenever they want without disturbing other patients.

4. According to the care providers participating in this study, there is an inadequate number of doctors and nurses involved in the care of the cardiac patients admitted to the CCUs in Gaza Strip. Therefore, it is recommended that the hospital administrations review the international standards of staff to patient ratios and try to increase the current number of staff to reach to equivalent ratios or to come as close as possible to these accepted ratios. It is also advisable in recruitment of new staff members to the CCU to recruit staff with previous experience in dealing with patients, since they may have dealt with patients with spiritual needs. Some could argue that increasing the number of staff will require some financial support. But recognizing that only three hospitals in Gaza Strip have CCUs, the number of extra staff will be a relatively moderate financial burden. As an initial step, hospitals may increase the number of nursing staff by one nurse in the morning and evening shifts and one cardiologist at each hospital. Providing spiritual care is expected to decrease the level of stress, anxiety, and pain of patients, which could act to help reduce the number of admissions, decreasing the length of their current hospitalization, and lowering the incidence of complications. The end result will be reflected in a reduction in the total cost of the treatment for cardiac patients. Thus, the money saved could then be used to cover the salaries of the new staff, if not more.
Implications for Public Health Policy

In spite of the fact that heart disease is the most common cause of death in the Palestinian population (Ministry of Health, 2005 and Palestinian Health Information Center, 2010), there are no accurate statistics available that reflect the incidence of heart disease in Palestine. This lack of statistics also applies to many chronic diseases, such as cancer and diabetes mellitus. Therefore, it is highly recommended that the Palestinian Ministry of Health moves to ensure that its health informatics system provide detailed statistics about the incidence of heart disease and other chronic diseases. Such statistics should be made available to the public through the website of the Ministry of Health. The availability of such information will allow access to health researchers to become better involved in research projects in line with their research interests and help in improving the general health of the Palestinian public.

Since heart disease is the leading cause of death among the Palestinians, it is imperative for the health care policy makers to implement some programs aimed at decreasing the incidence of heart disease among the Palestinian population. One of the approaches to reach this goal is to establish some health educational programs related to stress management, risk factors for heart disease, importance of exercise, weight reduction, and healthy diet.

Finally, it is recommended that the Ministry of Health survey the patients about the provision of spiritual care on a regular basis, examining their level of satisfaction with the spiritual care being provided. Based on the results of these
recommended surveys, some modifications can be introduced in an attempt to provide optimal spiritual care to targeted groups of patients.

**Implications for Public Administration**

The diagnosis of heart disease leads in many patients so afflicted to feelings of anxiety and fear of death and the unknown. Such anxiety and fear may contribute to complicating the prognosis of these patients. It is therefore recommended that health clubs, diagnosis-related groups, or support groups for patients diagnosed with heart disease be established. Patients who had the same diagnosis and have passed through the same experience will usually be able to provide other patients, especially those who are newly diagnosed with heart disease, with the best emotional and spiritual support. This will help in decreasing their stress and can contribute to improving their overall level of health.

Another recommendation for implications related to public administration is to heighten public awareness about the importance of spiritual care to all groups of patients and to heart patients in particular. The following are recommended as useful steps in this direction:

1. Interviews with experts of spiritual care and religious men to be made in and broadcasted by local TV and radio stations.
2. Articles about spirituality and spiritual care to be written in Arabic and published in the local newspapers.
3. Designing and distributing brochures that include information about spirituality, spiritual care and its importance and how it can contribute to improving the health of patients diagnosed with different diseases, including heart disease.

4. Designing some website pages in Arabic that help to explain spirituality and spiritual care and their role in health.

5. Making use of the Internet and establishing a page on some of the social networking sites such as Facebook or Twitter, where various patients, including those diagnosed with heart disease, can interact with each other. Such interaction may help in exchanging experiences and feelings which can assist in meeting their emotional and spiritual needs.

6. Collaborating with the Ministry of Religion to guide the speakers to talk about the topic in Friday sermons in the mosques.

7. Encouraging coordination between the Ministry of Health and the Ministry of Religion aiming at sending some personnel from the Ministry of Religion on regular visits to the hospitals.

Future Research

This dissertation study was designed to explore whether spiritual care is provided to cardiac patients admitted to CCUs, who should provide this care, the barriers that interfere with providing spiritual care to this group of patients and how to overcome these barriers. The main goal was to enhance the provision of spiritual care
to cardiac patients, which will lead to decreasing their level of stress, improving their prognosis, improving their quality of life, decreasing their rate and length of hospitalization and therefore, and reducing the cost of their treatment. To reach to this goal, it is clear that further research in the area of spirituality and spiritual care is needed. Some future focal areas for research projects:

This dissertation study explored whether spiritual care was provided to cardiac patients or not according to cardiac patients themselves. To add more depth to this topic, it is recommended that further studies be done to investigate the perception of healthcare providers and family care providers about the provision of spiritual care to cardiac patients. This is in addition to exploring the perceptions of cardiac patients, family care givers, and healthcare providers about the importance of providing spiritual care. It is also advisable to conduct a study in Gaza Strip that explores the perception of health policy makers about spirituality and providing spiritual care to cardiac patients. The results of these studies will contribute to motivating health policy makers to consider the issue of spiritual care as part of the agenda of health care policy. Hopefully, a new policy of including spiritual care in the health care system will be adopted by health care policy makers, in Gaza and elsewhere.

Another recommendation for future research is to repeat the studies undertaken here using other groups of patients, especially those with chronic diseases such as cancer, diabetes mellitus, and kidney failure. Repeating the studies including different categories of patients will add to the importance of the subject and will focus on the agenda of including spiritual care in the health care system in Gaza Strip.
While reviewing the literature, it was noticed that the greatest part of research related to spirituality and spiritual care was conducted in the developed and more industrialized world, mainly in countries with a Christian majority. It was noticed that there is a shortage of studies about spirituality conducted in developing and Islamic countries. Therefore, it is recommended that several studies about spirituality and spiritual care be conducted in developing and Islamic countries. Such studies will help healthcare providers to address the spiritual needs of clients with different religious backgrounds.

As noticed from the results of this study, one of the most important barriers reported by healthcare providers participating here was that they did not receive adequate education and training during their studies. It is therefore recommended that research be conducted on the perception of healthcare educators and current students in the health education institutions about spirituality and the importance of including spiritual care in their curricula, and to investigate the barriers that interfere with including spirituality as a focus in the current health education policy. The results of such studies will contribute to removing the barriers that may interfere with the inclusion of spiritual care in health education policy so as to produce future healthcare providers who will be better prepared and trained to provide spiritual care to their clients, including cardiac patients.

The design for this study was a cross-section design that aimed to explore the provision to spiritual care to cardiac patients, who should provide spiritual care, and barriers to providing spiritual care. To add more depth to the topic of spiritual care to cardiac patients, it would be useful to conduct a longitudinal investigation that
includes two groups, where spiritual care is provided to one group and a control group with no such care. The aim of this study is to measure the impact of providing spiritual care to cardiac patients. This topic can also be repeated using different groups of patients with different diseases and can measure the impact of providing spiritual care to them. The results of these studies will provide evidenced-based data to health care policy makers about the impact of providing spiritual care to these groups of patients, and it will also assist in evaluating the cost-effectiveness of providing such care to these groups of patients.

Summary

Heart disease is the leading cause of death among the Palestinian people. Cardiac patients are at higher risk for a more endangered life and delayed recovery from heart attacks when they experience stress (Harvard Men’s Health Watch, 2006). This renders them more liable to the possibility of repeated hospitalization. Consequently, preventing and relieving stress becomes a major concern for patients with heart disease (Oates, 2004). One of the approaches to reduce stress is the provision of spiritual care. At the clinical level, several studies emphasized that spirituality is associated with decreased anxiety and depression and increased capabilities in emotional coping (Mickley & Soeken, 1993; Tuck, 2001; Thoresen & Harris 2002).

In spite of the importance of providing spiritual care to all groups of patients, including cardiac patients, there is evidence in the literature, confirmed by this study,
that healthcare professionals focus on meeting the physical, social and psychological needs of their patient but seldom recognize the spiritual needs of the patient.

Although spiritual care is considered an important aspect of health care, there is no agreement about who should and would be able to offer spiritual care within the health care system. Although several hospitals in the Western countries assign chaplains and pastoral teams to address the emotional and spiritual needs of the patients, nurses, physicians, clinicians, and other health caregivers can play equally important roles (Clark et al., 2003).

Despite the fact that several hospitals in Western countries have begun to provide spiritual care (Clark, et al., 2003), in Gaza Strip there is no clear policy about providing spiritual care at the hospitals or other healthcare facilities. Therefore, this study aimed to assess if spiritual care was being provided to hospitalized cardiac patients who live in Gaza Strip, who should best provide this care; it explored the barriers to provision of such care, and how to overcome these barriers.

The responses of the cardiac patients who participated in this study revealed that there is a severe shortage of spiritual care provision to cardiac patients admitted to CCUs in Gaza Strip. When both groups of participants were asked about who should provide spiritual care to cardiac patients, the majority of the cardiac patients (n=159, 57%) reported that they preferred nurses to provide spiritual care to them, while responses of the healthcare providers participating in this study revealed some controversy in their answers. However, nurses were ranked first by five participants.

The responses of healthcare providers about the barriers they face in providing spiritual care were grouped into several thematic categories. These themes included
inadequate education and training, ambiguity about spirituality, inadequate time, shortage of staff, policy-related barriers, and individual-related barriers. Most of the barriers reported by the healthcare participants in this study were also reported in the literature.

To overcome these barriers, healthcare professionals suggested several strategies that were grouped into the following thematic categories: policy change, organizational interventions, including spirituality in health education (formal and informal) and miscellaneous interventions, such as educating the public about the importance of spiritual care, including an Imam (Muslim clergyman) in the health care team to provide spiritual care for patients, and assigning a senior nurse who has the experience in providing spiritual care to be available at each shift. These strategies suggested by the healthcare providers were consistent with the literature.

Because heart disease is the leading cause of death in Palestine and providing spiritual care to cardiac patient will help to decrease their stress, reduce their length of stay in the hospital, and lower the cost of their treatment, health policy makers need to pay more attention to this groups of patients and should move to adopt a spiritual care policy in the health care system. The suggested policy implications that came from this study include:

1. Adopting a spiritual care policy that mandates healthcare providers to provide spiritual care to cardiac patients admitted to CCUs at hospitals in Gaza Strip.

2. Modifying the health education policy to incorporate spirituality and spiritual care in the health education curricula.
3. Initiating policies to overcome the barriers that block the implementation of spiritual care. These policies should be directed toward increasing the number of the staff at the CCUs, providing in-service education and training to current staff, and including a clergyman (Imam) in the health care team.
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The Holey Quran.


APPENDICES
APPENDIX A

CONSENT FORM FOR CARDIAC PATIENTS
CONSENT FORM FOR PATIENTS

Spiritual Care of the Hospitalized Patients Following Admission to Cardiac Care Units: Policy Implication

You are invited to participate in a study being conducted by Mysoon Abu-El-Noor, a doctoral level student at the Department of Public Administration and Urban Studies at The University of Akron, Akron, OH.

The project focuses on “Spiritual care of the hospitalized patients following admission to cardiac care units: Policy implication”. If you decide to participate, you will be asked to take part in completing a questionnaire packet at a convenient time and safe place for you. The questionnaire should take no more than 20 minutes of your time. Participation in the project is completely voluntary. If you agree to participate, you may refuse to answer any questions and may withdraw from the study at any time without penalty. Your confidentiality will be protected throughout the study. Any data obtained from you through the interview will be kept confidential and will not be viewed by anyone but the researcher and her advisor. All identifying information will be retained in a locked cabinet or other locked storage area. The data will be kept for 2 years and will be destroyed upon completion of the project.

There are no anticipated benefits to you as a participant, aside from helping us have a better understanding about the barriers to and frequency of providing spiritual care to the cardiac patients in Gaza Strip hospitals and how these barriers could be eliminated. The risk to you from this study is the recall of unpleasant emotions and memories. The primary investigator or a trained data collector will be present throughout the entire process of conducting the interview. Phone numbers are available for professionals that can help you work through these emotions or concerns that have surfaced while participating in this study.

If you have any questions about the research project, you can call me at 0599014514 or my advisor Dr. Raymond Cox.

This research project has been reviewed and approved by The University of Akron Institutional Review Board for the Protection of Human Subjects. Questions about your rights as a research participant can be directed to Ms. Sharon McWhorter, Associate Director, Research Services, at 1-330-972-7666.

I consent to participate in this project.

Name _______________________________ Date _______________________________

University of Akron is an Equal Education and Employment Institution

APPROVED

IRB

Date 7/2/11

The University of Akron
APPENDIX B

CONSENT FORM FOR HEALTH CARE PROVIDERS
CONSENT FORM FOR HEALTH CARE PROVIDERS

Spiritual Care of the Hospitalized Patients Following Admission to Cardiac Care Units: Policy Implication

You are invited to participate in a study being conducted by Mysoon Abu-El-Noor, a doctoral level student at the Department of Public Administration and Urban Studies at The University of Akron, Akron, OH.

The project focuses on “Spiritual care of the hospitalized patients following admission to cardiac care units: Policy implication”.

If you decide to participate, you will be interviewed by the researcher at a convenient time and safe place for you and invited to answer some questions. The interview is expected to take about 30-45 minutes of your time.

Participation in the project is completely voluntary. If you agree to participate, you may refuse to answer any question and may withdraw from the study at any time without penalty.

Your confidentiality will be protected throughout the study. Any data obtained from you through the interview will be kept confidential and will not be viewed by anyone but the researcher and her advisor. All identifying information will be retained in a locked cabinet or other locked storage area. The data will be kept for 2 years and will be destroyed upon completion of the project.

There are no anticipated benefits to you as a participant, aside from helping us have a better understanding about the barriers to and frequency of providing spiritual care to the cardiac patients in Gaza Strip hospitals and how these barriers could be eliminated.

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I consent to participate in this project.

_________________________________________   _________________________
Name                                               Date

University of Akron is an Equal Education and Employment Institution

_________________________________________   _________________________
APPROVED                                        Date 1/1/11
IRB                                               The University of Akron

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I. Part one: Demographic data

The questions in the first section ask some background information about you and your illness related factors. These information are needed to group your response with those of person with the same background when the results of this study are analyzed.

1. What is your age?------------------------------------ (Please write your age in years).

2. What is your sex? (Please circle one choice only)
   A. Male                       B. Female

3. How much school have you completed? (Please circle only one choice for the highest level of school completed)
   A. None                       B. Primary Level
   C. Secondary Level           D. Tertiary Level
   E. Associate Degree          F. Bachelor Degree
   G. Master or higher Degree.
4. **What is your present working status? (Please circle one choice only)**

   A. Working full time (5days/week)
   B. Working part time (Less than 5days/week)
   C. Retired
   D. Disabled
   E. Unemployment wage
   F. Not working

5. **Where do you live? (Please circle one only)**

   A. North province
   B. Gaza province
   C. Middle province
   D. Khanyounis province
   E. Rafah province

6. **Do you live alone?**

   A. Yes ..........  B. No ........

7. **How long have you been diagnosed having a heart problem(s)?**

   ------------------------------- Year, ------------------------------- Month

8. **Do you have a history of another major chronic disease or surgical operation?**

   A. Yes  B. No

   If yes, please specify -----------------------------------------------

9. **How important is your faith to you? (Please circle one choice only)**

   A. Unimportant  B. Slightly important
   C. Moderately important  D. Important
   E. Very important.
II. Part two: Spiritual Care Rating Scale

The list of questions below is about providing different aspects of spiritual care by health care providers during your current hospitalization period. For each of the following questions please choose one answer which best describes the provision frequency of that aspect of spiritual care by health care providers to you. If you are unsure about how to answer a question, please give the best answer you can. Please mark the answer that best describes yours.

The numbered responses that following the set of question below reflect these responses categories.

1 = Never  2 = Rarely  3 = Sometimes  4 = Often  5 = Always
6 = Do not Know

<table>
<thead>
<tr>
<th>During your current hospitalization period. How often did the health care provider ask you</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
<th>Do not know</th>
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<tbody>
<tr>
<td>1. About your spiritual/religious beliefs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<td>2. About your relationship with God.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>6</td>
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<tr>
<td>3. About your relationship with yourself, and significant others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>4. About your religious practices that you like to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>5. 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?</td>
<td>1</td>
<td>2</td>
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<td>About religious books, articles, or symbols that you like to have</td>
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<td>7</td>
<td>About your favorite places to practice your religious activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
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<td>8</td>
<td>About changes in your spiritual/religious practices, and feeling toward being diagnosed with a cardiac disease.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>How they can help you to maintain your spiritual/religious strength after being diagnosed with cardiac disease</td>
<td>1</td>
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<td>10</td>
<td>What gives meaning and purpose to your life</td>
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<td>11</td>
<td>About your life story and your future</td>
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<td>12</td>
<td>About your sources of strengths and hope</td>
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<td>13</td>
<td>About goals and wishes that you have not met them yet</td>
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<td>14</td>
<td>About the most important relatives and/or friends to you</td>
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<td>15</td>
<td>What brings joy, pleasure, and peace to your life</td>
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<td>16</td>
<td>About your forgiveness for others and how to show forgiveness for yourself</td>
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<td>17</td>
<td>About the most loving things that you do for others or receive from them</td>
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<td>18</td>
<td>The appropriate time to ask and discuss with you spiritual/religious issues</td>
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<td>During your current hospitalization, how often did the health care provider</td>
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<td>Rarely</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
<td>Do not know</td>
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<td>19. Listen actively to you talk about your religious/spiritual beliefs, strengths, and your beliefs about God</td>
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<td>20. Give you the opportunity to talk about God and support coming from God</td>
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<td>21. Listen actively to stories from your spiritual life</td>
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<td>22. Offer to read from the Qur'an on you or to share prayer and meditation with you</td>
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<td>23. Help you to have suitable place to pray, to read from Qur'an, or to meditate</td>
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<td>24. 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)</td>
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<td>25. Help you listen to religious programs on radio or TV if available</td>
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<td>26. 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)</td>
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<td>27. Offer to discuss with you the difficulties of practicing prayer when sick</td>
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<td>28.</td>
<td>Arrange a visit by the hospital <em>imam</em> to comfort and support you if requested by you</td>
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<td>29.</td>
<td>Respect your privacy, dignity, religion, and religious and spiritual beliefs and rituals</td>
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<td>30.</td>
<td>Give your family the opportunity to visit you and to share prayer, reading from Qur'an, and meditation with you</td>
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<td>31.</td>
<td>Give your close friends the opportunity to visit you and to share prayer, reading from Quran, and meditation with you</td>
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<td>32.</td>
<td>Help you to become aware of meaning and purpose of life in facing illness and suffering that have come with the cardiac disease</td>
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<td>33.</td>
<td>Spend time with you giving comfort, support, and reassurance when needed</td>
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<td>34.</td>
<td>Create a feeling of kindness, cheerfulness, and intimacy when giving care to you</td>
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<td>35.</td>
<td>Help you to feel hopeful and to keep a positive outlook</td>
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<td>36.</td>
<td>Help you to complete unfinished business or activities</td>
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<td>37.</td>
<td>Help you in listening to music or practicing another art if requested by you</td>
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<td>38.</td>
<td>Make you laugh or introduce appropriate humor to you</td>
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<tr>
<td>39.</td>
<td>Hold your hand or put his hand over your shoulders to give you support and reassurance</td>
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</table>
II. Part 3

1. During you current hospitalization period, who do you think is the most appropriate person who can provide spiritual care for you? (Please circle one choice only)

A. Doctors       B. Nurses
C. Family members.       D. Close friends
E. Imam.               F. None

G. Other, please specify -----------------------------------------------
IV. Part 4

Is there anything else that you would like to tell us about the spiritual nursing care and your spiritual/religious care needs during your hospitalization period?

Thank you for your help
APPENDIX D

ARABIC VERSION OF THE INSTRUMENT

استبانة تقييم الاحتياجات الروحية التمريضية لمرضى القلب

الأسئلة الواردة في الجزء الأول تساءل عن بعض المعلومات الأساسية الخاصة بك وبخصوص بعض الجوانب ذات الصلة بمرضك. وهذه المعلومات يتم جمعها لغرض المقارنة و البحث العلمي.

1. ما هو عمرك؟
   أ. ذكر
   ب. أنثى

2. ما هو جنسك؟ (يرجى وضع دائرة حول خيار واحد فقط)
   أ. ذكر
   ب. أنثى

3. ما هي المرحلة الدراسية التي أكملتها؟ (يرجى وضع دائرة حول خيار واحد لأعلى مستوى من الدراسة)
   أ. لا يوجد
   ب. المرحلة الابتدائية
   ج. المرحلة الإعدادية
   د. الدبلوم المتوسط
   و. درجة البكالوريوس
   ه. دراسات عليا

4. ما هو وضع الوظيفي الحالي؟ (يرجى وضع دائرة حول خيار واحد فقط)
   أ. أُمِّر عملا كاملا (5 days/week)
   ب. أمر عملا جزئيا (أقل من 5 days/week)
   ج. متقاعد
   د. غير قادر على العمل
   و. لا عمل
   ه. عمل شبه موطن (عقد بطال)

5. في أي مستشفى ترقى انت الآن؟
   أ. الشفاء
   ب. شهداء الأقصى
   ج. ناصر

6. هل أنت تعيش وحده؟
   أ. نعم
   ب. لا (إذا كان الجواب نعم الذهب إلى السؤال 9)
7. كم مر من الوقت منذ تشخيص مرضك بالقلب؟
 سنة
 شهر

8. هل أنت مصاب بأي من الأمراض المزمنة أو أجريت لك عملية جراحية أخرى؟
- نعم
- لا
- إذا كانت الإجابة بنعم، يرجى تحديد ______

9. ما مدى أهمية الالتزام بالأمور الدينية بالنسبة لك؟ (يرجى وضع دورة حول خيار واحد فقط)
- أولئك الأهمية
- متوسط الأهمية
- مهم جدا

القسم الثاني

الأسئلة الأسئلة تتعلق بتقديم مقدم الرعاية الصحية جوانب مختلفة من العناية الروحانية لك أثناء إطلاقك الحالية في المستشفى.

يرجى الإجابة عن كل سؤال بال اختيار الإجابة واحدة بحيث تصف إجابتك ومدى أهمية كل بناء تتعلق بالعناية الروحانية لك أو أخرى يخص مواقف مقدم الرعاية الصحية على العناية بكل جانب من جوانب الرعاية الروحانية لك إذا لم تكن متأكدا من الإجابة عن أي سؤال يرجى اختيار الإجابة التي تراه الأفضل.

يرجى الإجابة بوضع دائرة حول الرقم علماً بأن الاستجابات المرفقة التالية للأسئلة تصنف بما يأتي:

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لا أعلم = 5
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 خلال إقامتكم الحالية في المستشفى، كم اعتاد مقدم الرعاية الصحية أن يسألكم:

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| 24 | يسهل عليك استخدام المصادر الروحانية المتوفرة في المستشفى مثل مصلى المستشفى أو توفير نسخ من القرآن الكريم أو الكتب الدينية الأخرى.
| 25 | يساعدك في متابعة البرامج الدينية في الدراسة أو التدريس إن وجدت.
| 26 | يبني لك الفرصة للمشاركة في إداء الشعائر الدينية مثل صلاة الجماعة أو الأعمال الروحانية. كريزة المرضي التي قد تترتب في الفهم الذي أنت فيه.
| 27 | ينقلق مك المعيقات أثناء الصلاة أثناء المرض.
| 28 | ينظم لك بناء على طلبك زيارة يقوم بها أحد الأبناء أو الوعظ أو الرسولين لتقديم عن نبأ ذلك.
| 29 | يحترم خصوصيتك كراملك وصلك وشعشك الروحانية.
| 30 | يبني الفرصة لاعلانك بزيارتك ومشاركتك الصلاة وقراءة القرآن الكريم.
| 31 | يبني الفرصة لأصحابك بزيارتك ومشاركتك الصلاة وقراءة القرآن الكريم.
| 32 | يساعدك في فهم معنى الحياة وهدفها وحالتك المرضية بعد تشخيص إصابتك بمرض القلب.
| 33 | يقضي ذلك وقتاً تليت في نفسك الطانية والسكينة ويشد من أزرك كما دعت الحاجة.
| 34 | يشترك بالطفا والبهجة والورود أثناء رعتك.
| 35 | يساعدك بالشعور بالأمل والتفاؤل.
| 36 | يساعدك في أن تتم أعمالاً أو أنشطة غير منجزة.
| 37 | يساعدك في الاستماع إلى الأناشيد أو ممارسة أي نوع من أنواع الفنون الأخرى إذا طلبت ذلك.
| 38 | يمسك بيدك أو يضع يده على كتفك ليشت أزرك ويثمنك.
| 39 | يمسك بيدك ويوفر لك جو من المرح بشكل يناسبك. 

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الجزء الثالث

أثناء أقامتك الحالية في المستشفى، من هو الشخص الذي تشعر أنه الأنسب لك لتقييم الرعاية الروحانية لك؟

أ. الطبيب
ب. الممرض
ج. أحد أفراد العائلة
د. أحد الأصدقاء
ه. رجل دين (إمام)
و. لا أحد

يرجى تحديد الشخص الآخر.

الجزء الرابع

هل هناك شيء آخر تود أن تخبرنا به عن الرعاية الروحية التمريضية و الاحتياجات الروحية / الدينية الخاصة بك خلال فترة العلاج الحالي في المستشفيات؟

شكراً على حسن تعاونكم
APPENDIX E

AGREEMENT OF DR. MUSA TO USE HIS INSTRUMENT FOR THE PURPOSE OF THIS STUDY

Please, Urgent seeking for academic help
2 messages

Mysoon Abu El Noor <nikal14@uakron.edu>
To: ahmad_cst1@yahoo.com

Dear Dr. Musa, Hello

I am sorry for bothering you too much, just I want to be sure that you received my previous email. I'm preparing my doctoral dissertation and very interested to have a copy of your dissertation and a permission to use the research tool you have used. Please let me know if you received my email or if the owner of this email is not Dr. Ahmed Musa please let me know. Thanks

Best regards
Mysoon Abu El Noor
PhD Student
Public Administration & Urban Affairs
University of Akron

Ahmad Musa <ahmad_cst1@yahoo.com>
Reply-To: ahmad_cst1@yahoo.com
To: Mysoon Abu El Noor <nikal14@uakron.edu>

Dear Mysoon,

Sorry for delay in responding to your email, but I was in vacation.

I am pleased to give you my permission to use my tool in your study, but I cannot give you a copy of my thesis as I have just see hard copy; the electronic copy was destructed by viruses. To solve this problem, I think that you can ask my university (The University of Edin) through your library at your university to order a copy of my thesis and in the reference of my thesis you can find names of large number of articles and studies hopefully it can help you

Please provide me with abstract of your study and findings later on.

If you have any question please let me know

keep in touch

Mysoon Abu El Noor
APPENDIX F

COMPONENT OF SEMI-STRUCTURED INTERVIEW FOR HEALTHCARE PROVIDERS

I. Part 1: Demographic data:

Please fill out the following sheet about yourself

1. What is your age? ------------------------------- (Please write your age in years).

2. What is your sex? (Please circle one choice only)
   A. Male                       B. Female

3. What is your highest degree of education? Please specify the field?

4. At which school/college and country did you receive your education?

5. What is your current position?

6. For how long you have been in your current position?

7. For how long you have been working in the health care section?

8. Place of work
   A. Shifa Hospital               B. Gaza European Hospital
   C. Nasser Hospital              D. Shohada Al-Aqsa Hospital

II. Part 2: questions to be asked by the interviewer

1. I would like to learn about how your education (formal and non-formal) addressed spirituality and spiritual care.
2. When you think of spiritual care, what comes to mind? What does “spiritual care” mean to you?

3. How important do you think is the provision of spiritual care to cardiac patients?

4. Who do you think should provide spiritual care to cardiac patients? And why?

5. What do you think are the organizational and administrative barriers and/or challenges that interfere with providing spiritual care to the cardiac patients?

6. What do you think that can be done to overcome barriers and challenges to providing spiritual care to cardiac patients at the levels of:
   a. Institution
   b. Health education
   c. Health care policy makers
   d. Others

7. Is there anything else that you would like to say about spiritual care that we have not talked about?
APPENDIX G

APPROVAL OF IRB AT THE UNIVERSITY OF AKRON TO CONDUCT THIS STUDY
Date:       July 8, 2009

To:         Mysoon K. Abu-El-Noor
            268 Crosby Street, Apt. 4
            Akron, Ohio 44303

From:       Sharon McWhorter, IRB Administrator

Re:         IRB Number 20090704 "Spiritual Care of the Hospitalized Patients following Admission to Cardiac Care Units"

Thank you for submitting your Exemption Request for the referenced study. Your request was approved on July 8, 2009. The protocol represents minimal risk to subjects and matches the following federal category for exemption:

☐ Exemption 1 - Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☒ Exemption 2 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.

☐ Exemption 3 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4 - Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5 - Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6 - Taste and food quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study's design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact me to discuss whether or not a new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. If the research is being conducted for a master's thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

☒ Approved consent form/s enclosed

Cc:       Raymond Cox - Advisor
Cc:       Stephanie Woods - IRB Chair
APPENDIX H

APPROVAL OF THE MINISTRY OF HEALTH AT GAZA TO CONDUCT THIS STUDY
"Spiritual Care of The Hospitalized Patients following Admission to The Cardiac Care Units: Policy Implication"

حيث ستمتقوم البحوث بإجراء مقابلات وتعيين استبانات من المرضى والعاملين في قسم القلب ومدراء التشريحة في المستشفيات التي لديها وحدات قلب (مجمع الناصر الطبي - مجمع ناصر الطبي - مستشفى شهداء الأقصى).

والتي بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء.

وتفضلوا بتقبل التحية والتقدير،

[Signature]

[Name]

مدير عام تنمية القوى البشرية

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Gaza  
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