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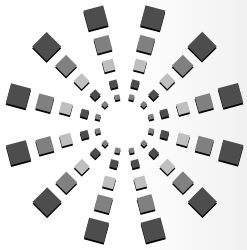

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Nurses Exploring the Spirituality of Their Patients With Cancer

Participant Observation on a Medical Oncology Ward

KEY WORDS
Cancer
Dutch Spiritual Care Guideline
Ethnographic
Nurses
Observing and exploring spiritual issues
Participant observation

Background: Attention for spirituality should be an integral part of professionals' caregiving. Particularly, nurses caring for patients with cancer might have opportunities to give attention to this dimension. **Objective:** The aim of this study was to gain insight in the way and extent to which nurses during daily caregiving observe and explore spiritual issues of hospitalized patients with cancer. **Methods:** We performed an ethnographic study with participant observation. Data were collected in 2015 during 4 shifts at the medical oncology department of a university hospital. The researcher, a spiritual care provider (chaplain) wearing the same kind of uniform as the nurses, observed the nurses, participated in their actions, and interviewed them after the shift. **Results:** Although the patients did send many implicit and explicit messages concerning spiritual issues, the nurses did not explore them. If noticed, 3 barriers for exploring spiritual issues were mentioned by the nurses: lack of time, conflict with their mindset, and being reserved to talk about such issues. **Conclusions:** During their daily caregiving to patients with a life-threatening illness, nurses have many opportunities to explore spiritual issues, but they do not often recognize them. If they do, they tend not to explore the spiritual issues. **Implications for Practice:** Communication training for nurses is necessary to develop skills for

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The authors have no funding or conflicts of interest to disclose.

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Accepted for publication May 29, 2017.
DOI: 10.1097/NCC.0000000000000526

exploring the spiritual dimension in patients with cancer. In such training, attention to the misconception that such a conversation requires a lot of time and for recognizing signals from patients inviting an exploration of their concerns is necessary.

Paying attention to physical, social, psychological, and spiritual care needs is considered important for patients' health, well-being, and recovery. This is reflected in healthcare policy at European and global levels.[1] The definition of palliative care by the World Health Organization specifically includes spirituality.[2] In Dutch healthcare settings, "spirituality" and "spiritual care" are discussed significantly more often in the last decade,[3] and recently, a clinical practice guideline for spiritual care in palliative patients has been published.[4] According to this guideline, attention to the spiritual dimension should be an integral part of the care provided by all healthcare providers, including nurses. However, in the Netherlands, as in other western countries, attention to this dimension is not an everyday practice.[5,6]

Nurses may, during their daily caregiving tasks, observe implicit or explicit signals from patients to share spiritual issues.[7] Patients with cancer can experience uncertainty regarding prognosis and deteriorating health, which can cause spiritual distress.[8] Facilitating factors for such distress are, for example, cancer recurrence, unrelieved physical pain, or regret of unhealthy behaviors in the past. These might reveal emotions, such as anxiety, panic, or depressed mood,[4] resulting in thoughts such as "My life is meaningless," "I am so alone," or "What if all that I believe is not true?".[9,10] Even during a stable illness period, the patient with cancer may have time to consider all that has befallen him/her and where it may lead, which can also cause spiritual distress.[4]

As an aid for nurses to explore the spiritual dimension during their daily caregiving, the Dutch Spiritual Care Guideline[4] lists 3 simple questions. These questions, derived from the Mount Vernon Cancer Network (MVCN)[11] are as follows: (1) "Is there at this time anything in particular that you are concerned about?" (2) "Where did you previously find support in difficult situations? (Family? World view? Music?)" (3) "Who would you like to have near you? From whom would you like to have support?" Through asking these questions, patients are invited to tell in their own words what they are most concerned about, and what, in this period and in the past, are their sources of strength. The answers also help to distinguish whether professional counseling might be indicated.

It is currently unclear whether nurses are willing and have the skills to integrate these questions into their daily work. Also not known is how patients seek attention to spiritual issues in their contacts with nurses. For these reasons, we decided to study whether nurses, during their care for hospitalized patients with cancer, recognize and use opportunities to talk about spirituality and whether they apply the 3 guiding questions of the Dutch Spiritual Care Guideline.

■ Methodology

Design

We performed an ethnographic observation study, meaning that the nurses, in their interaction and conversation with the patient, were studied systematically. This was combined with short interviews to reflect on the observations.[12] The researcher (J.v.M.) is also a healthcare provider (chaplain) and therefore regularly present at and familiar with the oncology ward of the hospital where the study took place. She is trained and skilled in exploring and mapping patients' spiritual dimension, as a consultant to spiritual care rather than as a traditional chaplain.[13] Rather than searching for predetermined or defined behaviors, she observed and listened in an open and inquisitive manner during the observation, while paying special attention to how, when, and whether nurses addressed the spiritual dimension with their patients. She also observed whether the 3 questions of the Dutch Spiritual Care Guideline—for screening the spiritual dimension—were used. At the end of the shifts, each observed nurse was interviewed by the researcher.

Initial Situation

Several months before the participant observation, an article was distributed among all nurses of the oncology ward on exploring the spiritual dimension of patients with cancer through the 3 questions of the Dutch guideline. During this period, implementation of the 3 questions was discussed during each of the weekly patient discussions the researcher attended. At the start of the participant observation, all nurses were aware of the existence of the 3 questions and the following definition of spirituality: "the dynamic of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred."[14,15]

Setting and Participants

The research was carried out at the medical oncology ward of an academic medical hospital of 700 beds in the southeastern part of the Netherlands. We used purposive sampling. Of the 40 nurses working at the department, who had all received the article on exploring the spiritual dimension and attended several weekly patient discussions about this topic, 4 nurses were selected, taking care that women and men, young and old, having shorter and longer years of experience, and being specialized in oncology or not were represented. After being informed about the concepts being studied, all 4 accepted the invitation to be observed.

Patients were informed about the observation by the researcher and nurse together at the start of the shift. The researcher introduced herself as being a researcher in the field of spiritual care and that she observed whether and how nurses give attention to this dimension. She told that, at any moment, they could ask for additional information, and they were told that they could refuse the researcher's further presence at any time. All patients gave verbal permission for the observation. Three

patients asked for additional information about the research, which they received.

The researcher, like the nurse, wore a white uniform. Through simple actions such as getting a glass of water, bringing the weighing chair, and opening and closing the curtain around the bed, the researcher participated in the actions of the nurses she observed. Patients sometimes asked the researcher questions or made comments in presence of the nurse. When the researcher interpreted these as an unfolding of the spiritual dimension and the nurse did not react on this herself, she sometimes integrated the 3 questions of the Dutch guideline in a conversation with the patient. In addition, the researcher forwarded the questions she received from the patients to the nurse, either on the spot or in the interview at the end of the shift.

Data Collection

The participant observation took place while accompanying the nurses during complete shifts. All observations and interviews were conducted in January 2015. Explanations to, and consent from, the nurses were given and obtained verbally beforehand. Starting from the research question, the observations and interviews were guided by the following subquestions:

1. In what (care) situations do nurses and hospitalized patients with cancer start to talk about spiritual issues?
2. Do nurses, in these cases, apply the 3 MVCN questions,[11] as suggested by the Dutch Spiritual Care Guideline?
3. What facilitating factors and barriers do nurses encounter that contribute to starting, or refraining from, conversations about spiritual issues?

Answers to subquestions 1 and 2 were obtained by means of participant observation and were, at the beginning of the shift, again openly presented to the nurses as the focus of the observation. The last subquestion (3) was studied by means of participant observation combined with the interview afterward. This interview included the following questions and themes:

- Did you discuss or explore the spiritual dimension?
- If so, in what way?
- If not, what were the reasons?
- If the researcher had noticed unused opportunities to talk about spiritual issues, the nurse was asked whether he/she had recognized these situations.

All field data collected were anonymized, that is, saved in a way not traceable to any person.

During the observation, the researcher took notes: dialogues and situations were sometimes recorded on the spot and other times less visibly in the hallway or nurses' office. These observations and dialogues are described in Tables 1 to 7. The interviews were audiotaped and transcribed. The observations and written interpretations based on the interviews, as well as the observation, were handed to the nurses, asking them whether they recognized the description derived from the observation (member check).

Ethical Considerations

The study was performed within the Dutch law and Good Clinical Practice guidelines. Because the study concerned observation of routine care, or the way nurses usually interact with patients, no permission of the medical ethical committee was required.

To guarantee anonymity, patient characteristics including quotes were adjusted to prevent recognition of the patient, and all nurses were mentioned or quoted alike and as a woman.

Table 1 • Feeling "Me" Again

A young woman sees to it strictly that her chemotherapy does not incur any delay. The nurse (n4) is irritated by this, feels hurried on and played out against the doctor. The spiritual care provider suggests the nurse she asks this woman about her concerns, why she is putting such pressure on time. The nurse sits with the woman and asks. The woman explains that in the hospital she is just another patient, surrounded by other people with their illnesses and their stories. Here she is just a woman with cancer. She makes no effort to hide her illness, does not wear a wig. "But at home…at home I put on my wig, my lipstick and return to my life. I am 'me' again. I can barely wait. However hard you people try; my feeling is I am shut in here. Confined. I do try my best to make something of it. But that uncertainty is there too and I don't want to be occupied with only that, but that's hard in here."

Data Analysis

Initially, the data were read and reread for familiarization. We inductively identified and indexed themes and categories. Afterward, all the data relevant to each category were discussed with 2 other researchers (M.G. and Y.E.) until consensus was reached. The key point about this process was inclusiveness; categories were added to reflect as many of the nuances in the data as possible—rather than reducing data—and so moving toward hypotheses or propositions.[16] The consolidated criteria for reporting qualitative research, that is, a checklist for explicit and comprehensive reporting of qualitative studies, was used.[17]

■ Findings

Four nurses were observed, 3 women and 1 man. Of these four, three had acquired the oncology specialization. The care the nurses provided took place in rooms for 4, 2, or 1 bed(s). The observation was conducted 3 times during a day shift and 1 time during an evening shift. At the start of their shift, each nurse confirmed being familiar with the 3 questions of the Dutch spiritual guideline as possible questions for exploring the spiritual dimension and to have taken note of the 3 subquestions of the study.

After each observed shift, the nurse was interviewed. When asked whether situations had occurred during the shift that had offered a clear entry or even an explicit invitation to explore or have a conversation about meaning, each nurse initially indicated not having recognized such situations. However, once the researcher offered examples she had observed that day and had herself even acted on a few times with or without the help of the 3 questions of the Dutch guideline, each of the nurses agreed to

Table 2 • Airsoft

Although the nurse (n2) informed the spiritual care provider at the start of her shift that she was ready for the "challenge" of entering into a meaningful conversation with this young, somewhat "tough" young woman, it did not happen during her shift. The woman was lying in bed all day, slept a lot, and, when awake, was busy with her laptop. The spiritual care provider then at the end of the day decided to ask this woman what she was concerned about. [Is there at this time anything in particular that you are concerned about?] She was lying on the bed at the time with her laptop on her lap and headphones on her head. She immediately took off her headphones and invited the researcher to watch photos and videos about Airsoft, a battle simulation game using replicas of existing weapons. She also showed her the leg that had received surgery and reported: "My hip joint was not optimal but when I had surgery on my leg I knew: what I want most, working with the Army, is not going to happen." She then talked about the group of boys and girls of which she was part: "some I have known since kindergarten, others from high school." [Where did you previously find support in difficult situations?]

Several of them received training at the Army. Engaging in Airsoft together approximated her desire to take part in combat units the most. "Next week I will undergo two more treatments. Two girlfriends will accompany me to the hospital. We will spend the night at relatives in Nijmegen and the next day I get the second treatment." [Who would you like to have near you for support?] [Who would you like to have near you? From whom would you like to have support?]

having recognized several of such occasions. The nurses proceeded by pointing out all sorts of barriers that often kept them from entering into a conversation. During these observations and the interviews, in which the observer and the nurse reflected on these observations, we concluded that no new barriers or deductive factors arose during the fourth interview. The barriers derived from observation and interviews could be subdivided into 3 main themes: lack of time, mindset, and reserve.

Table 3 • Faith as Major Support

In the morning, the spiritual care provider asks a patient the 3 questions of the Dutch guideline. The nurse (n2) nudges her afterward saying: "I heard the three questions!"[Is there at this time anything in particular that you are concerned about?] The patient tells how he was given a diagnosis of cancer during the summer. This came after his divorce and soon after he lost his job as well: "Life can be harsh, yes. But what concerns me too are all these refugees and wars. Can we not live with more love rather than violence?"

[Where did you previously find support in difficult situations?] "My faith, that has been a major support. And the people of our church. I sing in the church choir, that has helped me tremendously. But there is an anger in me too…. Why does God allow this to happen? There is that as well!"

[Who would you like to have near you? From whom would you like to have support?] "My brother. He is always there. He takes me to the hospital and he picks me up. Our relationship has only grown tighter since I am divorced and have cancer. He's always there for me, in every conversation with the doctor. We're very close."

Table 4 • Going Home Today

While he was having blood samples taken, the spiritual care provider asked a patient why it was so important to him to be able to get home today. [Is there at this time anything in particular that you are concerned about?] He explained that, a day before, it was exactly 1 year since his mother passed away. "My mother was much more than a grandmother to my children, she helped raise them. She was my best friend. I miss her dearly." [Where did you previously find support in difficult situations?] Together with his children, he had had a statuette made, which they would place at her grave 1 year after her passing. Because of the therapy, he could not be present. Because of the bad weather the previous, day they had postponed it. It was now to take place this evening, and he wanted to be there. "If I would have to get back to the hospital afterwards then that's OK. But for now I first want to get home. Take part in the remembrance of her demise." [Who would you like to have near you? From whom would you like to have support?]

After our talk he says:

"I sat with a psychologist in a room here once. Then I thought: I won't do that again. But here, like this, at the bedside; then I find: it's good to tell my story."

Barriers

LACK OF TIME

Three of the 4 nurses indicated that there was little or no time to have a conversation about spirituality. All thought such a conversation would take a lot of their time.

> I guess I cannot start such a conversation knowing I have to be on my way again. That is the dilemma sometimes; knowing things are waiting for me and then I will not inquire further.

According to the nurses, the afternoon usually offered more space and time for such conversations than the morning:

> You should not try and do that in the rush of your work. (…) that to me is the professionalism of a nurse, that you plan to integrate that, as part of your care, later in the day. (n2)

Table 5 • Yesterday I Was in the Disco

While speaking with a patient: The first situation involves a young woman who, in front of the nurse (n1), says: "Pretty weird, one day you're at the disco and the next day you're so whacked." The nurse does not respond. The same woman then turns to the spiritual care provider saying, "Are you familiar with that, that people who get cancer want to go over everything?" The researcher directs the question back to the nurse who answers "no, not weird at all. Many people do," and asks whether he can measure the patient's blood pressure.

Table 6 • A Priest From Africa

Image: At the start of the shift, the nurse (n1) tells the spiritual care provider that she wishes to "offer support" to a patient coming from an African country because "this man hardly asks for anything and that concerns me." The nurse knows that his church has "something important" coming up shortly and that he is "a priest." The patient wears a T-shirt that day, bearing in big letters: "God created me for a reason." During the day, the nurse discusses with the man neither about the date on which "something important" is to happen nor about his faith nor about the words on his T-shirt.

MINDSET

The interviews revealed that the nurses' mindset also represented a limiting factor. They expressed how they spent a substantial part of their time completing and inquiring in service of checklists and scoring lists; during their shifts, this needed to have their full attention ("you will be held accountable through these lists" [n3]). This made it difficult to be able to hear a patient's question or comment as an unfolding of the spiritual dimension or as an entry or invitation to a conversation about spirituality. Most of the time, they carried a computer in which to directly insert scores. Watching patients and listening to them have, to a substantial degree, given way to keeping track of scores:

> Not my clinical eye but the MEWS [Modified Early Warning Score] has to tell me how the patient is doing. Talking about this, this nurse realizes: "that I often primarily ask closed questions." (n3)

Another barrier was that, because of personal circumstances or an incident, their mindset did not allow for a conversation about meaning:

> It also depends on how I am going into my shift. Sometimes it has to do with me personally. (…) There are days when I am "doing my tasks" mostly and other days when I feel I have a bit more to give. (n3)

Another nurse said:

> Sometimes I just do not succeed. Then I am already full (…) It has also happened; someone had passed away in a room. And then there was a new patient. But my feeling was that that room still belongs to that other patient. Then I could not start a conversation. That was actually like I did something really nasty. But I did not have the headspace yet. (…) I think with every patient, every room, you have to switch again (…) our admissions, our experiences of one to the other, are very quick. (n4)

RESERVE

Apart from lack of time and mindset, nurses mentioned a number of factors pointing to reluctance to engage in a conversation about meaning. All 4 nurses indicated that intruding on the privacy of the patient represented 1 such factor. Speaking about meaning, according to them, was difficult to reconcile with the possibility that fellow patients and others might be listening in. Considerations that the conversation could be overheard by a third party could be a reason not to enter into the conversation. Two nurses stressed specifically that they experienced this as an impeding factor to address the spiritual dimension.

In addition, all 4 nurses indicated that talking about meaning might be stressful to patients. Not every patient has a need for this, they said. They also wanted to avoid that different nurses would start a conversation with the same patient about his concerns:

> You should be careful not to over ask people. (n2)

The nurses expressed as well that, because much work needed to be done during a shift, they often had to set other priorities.

The personality of the patient also could contribute to reservedness in the nurse with regard to entering into a conversation:

> When you don't connect with people then I also do not feel like asking about it. Or when people are really bothersome. When you feel there is no rapport. (n2)

Patients were also said to choose to start a conversation with a certain nurse and not the other.

> …that some people also know: with you I get along. So with you I like to share my story. (n3)

Finally, the nurses indicated in the interviews that it could be demanding for themselves as well to frequently have such conversations:

> You cannot keep this up with all people, every day, at this rate…for it demands a lot of you because you have to reveal a lot about yourself too. (n2)

Sometimes, nurses deliberately let moments pass that presented possibilities for conversation:

> You don't always feel like it, you see. (n2)

Conducive Factors

In the end, situations were presented to the nurses in which talks about spirituality during their shifts actually had taken place. The reactions that followed identified several factors conducive to conversations about spirituality: suggestions from the spiritual care provider, observation of the spiritual care provider, a renewed viewing of the situation, and continuity of care.

SUGGESTIONS FROM THE SPIRITUAL CARE PROVIDER

On occasion, the researcher, upon explicit request of the relevant nurse, pointed to a clear effort a patient had made to engage in a

Table 7 • Spinning Mind

Nursing action: The nurse (n3) has scheduled for the afternoon that a patient's line of tube feeding should be rinsed out/flushed with water. Because the patient will eventually have to be able to do so herself, she wants to "practice" with the patient at a less busy time. That afternoon, she sits at the bedside of the patient, noting that the screw on the spray appears worn, rotating with no grip. The patient reacts saying: "Well, how appropriate to my own condition. My mind spins madly on ever since I lost my grip on things." The nurse does not respond to this remark by the patient but continues with the operation and explanation.

conversation about meaning. The nurses knew the researcher first and foremost as spiritual care providers. They interpreted being shown instances and opportunities for entering conversations as suggestions from the discipline of spiritual care. These suggestions seemed helpful for engaging in a conversation.

In the interview, looking back to this conversation (Table 1), the nurse in question was asked whether this exploration brought her or the patient anything:

> Yes, it makes a difference. Especially that the woman showed her vulnerability; what motivated her to act in such a way. (…) Now that I know what caused her to be so on top of the therapy, then that offers an explanation. (n4)

Another nurse remarked, after a similar encouragement to explore and the resulting conversation:

> You also get useful information from there. Also just to be able to better care for your patients. Small pieces of personal information also enable you to develop a certain connection with someone. It also ensures that you can support people in another way. I now like knowing that this man is expecting his second child and does not know what the future holds for him and whether or not he is going to be able to see it. It gives me a lot of information on him. (n3)

This nurse spontaneously made notes in the electronic patient file after her conversation with the patient:

> Sure! But to me it's not just about that information but also about him being able to be here as the person he is. (n3)

OBSERVATION OF THE SPIRITUAL CARE PROVIDER

The researcher occasionally had short conversations with the patients; whenever possible, she used the 3 questions from the MVCN (see Tables 2–4). In the interviews, nurses indicated that they had heard these conversations, either completely or in part. During the interview, a nurse informs the researcher that she had already observed her before this in her work as a spiritual care provider:

> I have often seen you talking to patients; I then did not stand close, but now my idea has been confirmed: people quickly feel like they can share their story with you. I then try to analyze what that is; that interests me. (…) I admire that. (n3)

SITUATIONAL APPRAISAL

During the interviews, the researcher discussed several situations (Tables 5–7) with the nurses, which might have been an opening to (further) explore the spiritual dimension but where this exploration did not occur. By analyzing these situations, they recognized opportunities that they had not noticed during their service. Opportunities presented themselves while speaking with patients, through visual images/objects and during nursing actions.

This first situation (Table 5) contains an explicit invitation to talk by a young woman. The nurse responded in the interview: "Yes, that's right. Now that I hear you say it. I did not pick up on that (…)." (n1)

The researcher recalled with the nurse (situation, Table 6) that she had not given attention to the spiritual dimension the entire day, although she had intended otherwise at the start of her shift. Nurse: "I think you're right. I now wonder: why did I not do that? I can say well, I was busy with other things, which is the easiest way out. But I guess what you're telling me now about this patient, for me did not carry that charge." (n1)

The researcher assesses a situation (Table 7) with the nurse where, during a simple nursing act, a patient tells her that she experiences a restless mind. Reviewing this together, the nurse informed the researcher that "What I notice about you: you are very observant, to what you see in people, and you respond to that. And that way you create an entry with people. And what I observe in myself, now that I walk with you: I actually ask closed questions pretty often. I notice: you often let the story come from the people themselves. That's a big difference." (n3)

CONTINUITY OF CARE

The interviews showed that providing care to the same patients on consecutive days promotes intimacy between nurses and patients and facilitates conversation, also on the spiritual dimension. In the words of one of them: "Then you can keep an extra eye on this one this day, on that one the following, and that other one the next day. (…) Especially in terms of this dimension. I would really like to see that more attention was paid to continuity of care on all dimensions!" (n2)

■ Discussion

During the participant observations in an oncology ward, there were no (care) situations where nurses explored spirituality with patients. Multiple situations occurred in which patients gave nurses explicit or implicit signals to discuss existential issues. In most cases, nurses seemed not to have spontaneously recognized these signals. However, when the researcher mentioned the situations during feedback, they acknowledged all of them. Accompanying the nurses, the researcher detected signals that patients often offered as an opening to engage in a conversation about what preoccupied them the most. Because the nurses did not, several times, she then asked the 3 questions of the Dutch Spiritual guideline.[4] Besides, patients shared their concerns spontaneously to the researcher during moments of silent presence. Nurses indicated that they experienced 3 barriers that made them not to engage in this type of conversation: lack of time, a mindset unattuned to exploring, and reluctance to burden patients or others, including themselves, with exploring the spiritual dimension. Similar results were found in a survey among physicians in academic hospitals in the Netherlands.[18]

In line with Balboni et al,[6] the nurses observed in our study proved to be sympathetic to discussing spiritual issues. However, this attitude was different from the actual spiritual care they rendered.[5] Molzahn and Sheilds[7] also mentioned that it is not clear why nurses are reticent to discuss spiritual issues with people for whom they provide care, despite evidence of the positive effects of spirituality on well-being. According to Molzahn and Sheilds,[7] nurses providing spiritual care are expected to be able to use language

of human experience (such as the formulation of the 3 questions), to understand language belonging to institutionalized religions, and to be sensitive to the "unspokenness" that pertains to the mystery and the mysticism inherent in spirituality. McSherry and Ross[8] state that, in nursing, there is a need for the concept of spirituality to be developed in a meaningful and rigorous manner. Our observation indicates that nursing practice offers multiple opportunities to explore or identify the spiritual dimension of patients.

The mindset of the nurse at the bedside differs from that of the spiritual care provider. A patient's comment, "Is it strange that people who get cancer want to evaluate their entire life?", was heard by the nurse as a question to which an answer was expected and by the researcher as an unfolding of what concerned this woman in her illness. In daily nursing practice, where much time and effort go to measuring physical aspects, creating time and space for "the unfolding of the clients' tale" is a challenge.[19] Lack of skills pertaining to the spiritual dimension may require an interdisciplinary approach if it is to take a full role in daily practice in the care provided to patients, in addition to the more common focus on the somatic, psychological, and social dimensions.[20]

Strengths and Weaknesses

Our results are based on observations of daily oncology practice, which provided insights in what takes place. A limitation of the study is that it was conducted in only 1 department of only 1 hospital in the Netherlands. In addition, only a limited number of nurses were observed. Yet, this number was sufficient to reveal multiple opportunities in nursing practice to explore the spiritual dimension. To guarantee anonymity of the nurses, gender was not reported in the results section. This implies that gender-sensitive examination of the data was not possible. That the researcher also worked at that ward as a spiritual care provider may have influenced observing objectively. However, it also made the nurses feel at ease in the presence of the researcher, which made the situation more natural.

■ Conclusions and Recommendations

Hospitalized patients provide many opportunities to nurses to explore the spiritual dimensions, but because of a diversity of reasons, nurses do not tend to recognize them. To close this gap, nurses should be trained to allow them to naturally, and in a way commensurate with their work, explore the spiritual dimension of patients and to identify a need for specialist counseling or crisis intervention. This certainly applies to the care of patients with cancer, in whom the experience of a life-threatening illness and the uncertainty regarding diagnosis and of facing death can cause spiritual distress.

ACKNOWLEDGMENTS

We are grateful to the employees of this department, and the 4 observed nurses in particular, that they have agreed to the publication of data collected and therefore have made this publication possible.

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