Support Care Cancer (2013) 21:2991–2998
DOI 10.1007/s00520-013-1863-y

ORIGINAL ARTICLE

Surprising results regarding MASCC members' beliefs about spiritual care

Lois M. Ramondetta · Charlotte Sun · Antonella Surbone · Ian Olver · Carla Ripamonti · Tatsuya Konishi · Lea Baider · Judith Johnson

Received: 7 January 2013 / Accepted: 21 May 2013 / Published online: 18 June 2013

Abstract
Background Through our survey of Multinational Association of Supportive Care in Cancer (MASCC) members and its analysis, we sought to gain a broader, more inclusive perspective of physicians' understanding of patients' spiritual care needs and improve our approach to providing spiritual care to patients.
Methods We developed a 16-question survey to assess spiritual care practices. We sent 635 MASCC members four e-mails, each inviting them to complete the survey via an online survey service. Demographic information was collected. The results were tabulated, and summary statistics were used to describe the results.
Results Two hundred seventy-one MASCC members (42.7 %) from 41 countries completed the survey. Of the respondents, 50.5 % were age ≤50 years, 161 (59.4 %) were women and 123 (45.4 %) had ≥20 years of cancer care experience. The two most common definitions of spiritual care the respondents specified were "offering emotional support as part of addressing psychosocial needs" (49.8 %) and "alleviating spiritual/existential pain/suffering" (42.4 %). Whether respondents considered themselves to be "spiritual" correlated with how they rated the importance of spiritual care ($p \leq 0.001$). One hundred six respondents (39.1 %) reported that they believe it is their role to explore the spiritual concerns of their cancer patients, and 33 respondents (12.2 %) reported that they do not feel it is their role. Ninety-one respondents (33.6 %) reported that they seldom provide adequate spiritual care, and 71 respondents (26.2 %) reported that they did not feel they could adequately provide spiritual care.
Conclusions The majority of MASCC members who completed the survey reported that spiritual care plays an important role in the total care of cancer patients, but few respondents from this supportive care-focused organization actually provide spiritual care. In order to be able to provide a rationale for developing spiritual care guidelines, we need to understand how to emphasize the importance of spiritual care and, at minimum, train MASCC members to triage patients for spiritual crises.

Keywords Spiritual Care · Supportive Care · MASCC · Spiritual Assessment

L. M. Ramondetta (✉) · C. Sun
Department of Gynecologic Oncology and Reproductive Medicine, The University of Texas MD Anderson Cancer Center, 1155 Herman Pressler, Houston, TX 77030, USA
e-mail: lramonde@mdanderson.org

A. Surbone
Department of Medicine, New York University, New York, NY, USA

I. Olver
Cancer Council Australia, Sidney, Australia

C. Ripamonti
Supportive Care Cancer Unit, IRCCS Foundation, National Cancer Institute of Milano, Milano, Italy

T. Konishi
Medical Corporation Soshukai, Miyagi, Japan

L. Baider
Department of Medical Psychology, Sharett Institute of Clinical Oncology and Radiology, Hadassah University Hospital, Jerusalem, Israel

J. Johnson
HealthQuest, Minneapolis, MN, USA

Introduction

In 2009, Puchalsky et al. [1] defined "spiritual care" in medicine and differentiated physicians', nurses', and social workers' roles in delivering spiritual care from those of clergy

and psychiatrists. The authors recommended that every patient should at least undergo "spiritual triage" to determine whether the patient is experiencing a spiritual crisis and/or negative religious coping that could interfere with the patient's ability to adjust to a cancer diagnosis. Puchalsky et al. defined spirituality as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred."

Though, for many people, spirituality is primarily expressed through religious beliefs and rituals, spirituality and religiosity are not superimposed. Rather, the notion of spirituality may encompass religiosity but then goes beyond it, extending to anything that comes from the spirit or the "breath of life." In the present paper, we will use spirituality in its broader meaning, while referring to religiosity when relating to specific data about it, as they appear in the medical literature.

Spiritual well-being and spiritual care are important to individuals with a cancer diagnosis at all stages of their illness and especially at the time of progression and toward the end of their life. In cancer patients, a sense of spiritual well-being has been associated with lower levels of anxiety and depression, a reduced sense of isolation, easier adjustment to the effects of cancer and its treatment, and increased ability to enjoy life during treatment [2–4]. Patients with advanced cancer who received less spiritual care than desired reported having significantly more depressive symptoms and less meaning and peace than patients with advanced cancer who received the spiritual care they desired ($p=0.042$) [5]. Further, patients with improved spiritual well-being appear to have improved pain control. By contrast, studies report that negative religious coping has been associated with distress, confusion, depression, and poor quality of life in cancer patients [6, 7].

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

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

Methods

This study was approved by the institutional review board at The University of Texas MD Anderson Cancer Center. The Psychosocial Study Group developed a 16-question survey that asked participants about their experience with and perceptions of spiritual care and vetted it over two annual meetings in 2009 and 2010. In order to gather as many respondents as possible, we sent all 635 MASCC members four e-mails between February 2 and 22, 2011, inviting them to complete the survey via SurveyMonkey, an online survey service [13]. The e-mails included an introductory letter assuring the potential participants that their identities and responses to the survey would remain confidential and that their completion of the survey would constitute their consent to be included in the study. They were also reminded not to take the survey more than one time. Demographic information collected during the survey included participants' age, gender, country of birth, country of practice, discipline, and years of experience. The demographics were tabulated, and summary statistics were used to describe results. Investigators involved in database management and statistical analyses did not have access to the identities of the study participants. Chi-square tests were used to compare group differences for categorical variables. Mann–Whitney and Kruskal–Wallis tests were used to evaluate group differences for continuous variables. Specifically, gender comparisons were done by Mann–Whitney tests, groups of 3+ categories were all done by Kruskal–Wallis test. No adjustments were made for multiple comparisons. Comparisons by age groups were done via Kruskal–Wallis; they were not adjusted for multiple comparisons. Where appropriate, the odds ratio (OR) was calculated by simple logistic regression. P values$<.05$ were considered statistically significant. SPSS version 17.0 (SPSS, Inc., Chicago) was used to analyze the data. The Appendix contains a list of the survey questions and response categories.

Results

Of the 635 MASCC members we invited to participate in the study, 271 members (42.7 %) from 41 countries completed the survey. The demographic characteristics of the respondents are shown in Table 1. Over half of the respondents were

Table 1 Demographic characteristics of respondents (N=271)

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

[a]Not specified for one respondent

women. The age groups with the highest proportion of respondents were the 50–60-year-old (36.2 %) and 40–50-year-old (26.9 %) groups. The years of practice experience was well distributed, with those having 20–25 years of experience comprising the largest group (17.3 %). The majority of respondents practiced in North America (42.4 %), followed by Europe (35.4 %) but also included respondents from Asia, Africa, and the Middle East. Physicians comprised 46.9 % of the study respondents, followed by nurses, allied health professionals, and dentists. The Appendix shows key survey questions and responses.

Definition and importance of spiritual care

The first two questions in the Appendix asked respondents to define spiritual care in their professional practice and to rate the role of spiritual care in the overall care of cancer patients on a 10-point scale, from 0 ("not at all") to 10 ("most important"). Respondents most commonly defined spiritual care as "offering emotional support as part of addressing psychosocial needs" (49.8 %) and "alleviating spiritual/existential pain/suffering" (42.4 %). The median overall rating for all respondents for the role of spiritual care was 7 (range, 1–10). Ratings did not differ by gender (median=7 for both men and women, p=.68). Although not statistically significant, palliative care nurses and palliative care physicians rated the role of spiritual care as more important than other disciplines (median scores= 8 vs 7, p=.10). When scores were examined by age group, there was a trend for younger respondent groups to give ratings that reflected a greater importance of the role of spiritual care (p=.08). The two youngest groups (20–30 years and 30–40 years) rated spiritual care as an 8, the 40–50-year-old and 50–60-year-old group rated the importance as a 7, while the oldest respondents (60+years old) rated the importance of spiritual care at a 6. Respondents who considered themselves spiritual felt that the role of spiritual care was more important than respondents who did not consider themselves spiritual (median=6 vs 7.5, p<0.001). The third question pertained to spiritual practices. The most common spiritual practices included music therapy (42.4 %), art therapy (29.5 %), dignity therapy (27.7 %), and yoga (26.9 %), and healing touch (24.4 %).

We then asked survey takers if they thought their role was to explore the spiritual concerns of patients, almost half of the respondents answered "sometimes" (49 %), over one third answered "yes" (39 %), while the remainder answered "no." Of those who answered "sometimes," 41 % were non-palliative care physicians, 22 % were nurses, 17 % were allied health professionals, 11 % were palliative care physicians, and 8 % were dentists. Of those who answered "yes," 24 % were non-palliative care physicians, 36 % were nurses, 10 % were allied health professionals, 21 % were palliative care physicians, and 9 % were dentists. Of the palliative care physicians, 59 % answered "yes" and 41 % answered "sometimes." The majority of non-palliative care physicians answered "no" (43 %) or "sometimes" (41 %), while only 27 % answered "yes." While all palliative care physicians and nurses indicated they accepted the role of providing spiritual care, only 15 % of medical oncologists and 9 % of oncology nurses indicated their acceptance. The role of exploring patients' spiritual concerns was not associated with age or gender. Similarly, belief that it was one's role to do this was not associated with whether if one referred patients for spiritual care assessment, whether respondents had spiritual training or education, years of practice, or whether respondents felt they could adequately provide spiritual care. When respondents who indicated they do not conduct their own spiritual assessment were asked whether they refer patients to someone else for spiritual care assessment, 9.2 % indicated "always," 18.5 % said "usually," 45.8 % said "sometimes," 14.9 % said "seldom," and 11.6 % stated " never."

Personal spiritual inquiry

Forty percent of respondents reported that they are not actively pursuing spiritual inquiry; the majority of those respondents (80 %) reported that they had not pursued spiritual training to help provide spiritual care for cancer patients in the past 2 years. Of the 50 respondents who pursued training to help patients, 38 (76 %) read books and 29 (58 %) attended seminars on spirituality. "Nonspiritual" respondents were significantly less likely than "spiritual" respondents to perform personal spiritual inquiry in the form of spiritual practice or contemplation ($p \leq 0.001$). The "spiritual" are pursuing their own spirituality by way of books ($p=0.004$), contemplation ($p=0.03$), and seminars in spirituality ($p=0.049$). Although not statistically significant, the group with the highest proportion of respondents who had undergone spiritual training in the past 2 years was the group with those who had been in practice for 5 to 10 years ($p=0.09$).

Over one third of the respondents reported they seldom provide adequate spiritual care, and more than one quarter do not feel they can provide adequate spiritual care (Table 2). One third of the respondents stated that they adequately provided spiritual care most of the time. The majority of respondents who reported that they seldom provide adequate spiritual care or do not feel that they could adequately provide spiritual care were women (55.3 %). Of the respondents who reported that they either seldom provided or could not adequately provide spiritual care, 100 (62 %) were age 40–60 years, 39 (24 %) were age <40, and 22 (13 %) were age >60 years; 64 of these respondents (40 %) practiced in Europe, and 63 (39 %) practiced in North America. The majority (75 %) had been in practice >10 years.

Method, timing, barriers of spiritual assessment

Sixty-nine percent of the respondents reported performing spiritual assessments repeatedly throughout the illness trajectory, and 24 % reported that they believe that spirituality should be assessed soon after diagnosis. The overwhelming majority of respondents reported that they do not use a standardized questionnaire to assess their patients' spiritual needs (90 %). Those who did used the FICA; others reported using the SPIRIT, HOPE, SBI, and/or FACIT-Sp.

In reply to the question "[What do] you feel keeps you and others from providing spiritual care?," 55 % reported that they believed they needed more training, 23 % indicated the need to refer their patients to a specialist, 31 % stated that they preferred referring their patients to chaplaincy, 111 (41.0 %) reported that they did not have enough time, and 23 % stated that they did not feel it was appropriate to do so.

Table 2 Disciplines of respondents who answered "seldom" or "no" to Question 13 (In your your opinion, can you adequately provide spiritual care?")

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

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

One third of the respondents indicated they had some form of training or education regarding spiritual care. The proportion of women who received training or education was higher than that of men who received training or education (37 % vs 26 %, respectively), but this difference was not statistically significant. In fact, the majority of the respondents had not had any spiritual care training, and most indicated that basic knowledge and skills in recognizing spiritual issues were necessary in order to provide spiritual care to patients. There was no significant difference between the proportions of "spiritual" and "nonspiritual" respondents who reported that they needed more training, needed to use referrals, or did not have enough time to fulfill the spiritual care needs of their patients. Respondents who considered themselves "spiritual" were more likely to agree that the need to have basic knowledge and skills (OR=2.07; (95 % confidence interval (CI), 1.1, 3.9), $p=.025$) and consulting with a trained chaplain were necessary to provide spiritual care (OR=2.37, 95 % CI (1.24, 4.54), $p=.009$). (Question 15 analyzed by responses to Question 19) Half (50.6 %) of the respondents indicated that lack of training and one third of respondents said lack of time (37.3 %) prevented them and colleagues from providing spiritual care.

Participants who are "spiritual" vs "nonspiritual"

The majority of respondents (76 %) considered themselves to be "spiritual." Sixty-eight percent of the respondents from Europe, 85 % of the respondents from North America, 43 % of the respondents from Australia, and 79 % of the respondents from Asia considered themselves to be spiritual. The proportion of "spiritual" respondents who claimed a religious category was significantly higher than that of "nonspiritual" respondents (78 % vs 46 %, respectively; $p<0.001$). The respondents were relatively evenly split between men (45.9 %) and women (54.1 %), and distributed across the age groups. Individuals who considered themselves to be spiritual were much more inclined to claim a religious category (OR=4.36, 95 % CI (2.36, 8.05), $p<.001$). Interestingly, 55 % of people who did not claim a religious category consider themselves to

be spiritual. Although professional discipline was not associated with whether respondents thought they were spiritual, the majority of individuals across disciplines indicated they were spiritual (77 % of physicians other than palliative care, 84 % of palliative care physicians, 79 % of nurses, 66 % of allied health professionals, and 68 % of dentists).

Of the 71 respondents who did not claim a religious category, 45 (63.4 %) reported that they seldom or could not provide adequate spiritual care, but this was not statistically significant. Of the 61 respondents who reported that they were not spiritual, 50 (82 %) claimed that they seldom or could not provide adequate spiritual care ($p=0.001$).

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

Role in exploring spiritual concerns with patients was associated with whether respondents viewed themselves as spiritual ($p<.001$, chi-square analysis). The majority of patients who did not consider themselves spiritual said they sometimes viewed their role was to explore the spiritual concerns of patients (64 %), while 16 % of these individuals did feel it was their role, 20 % did not. In comparison, 46 % of individuals who said they were spiritual also felt it was their role, while 10 % did not, and 44 % said "sometimes." Referral of patients to someone for spiritual assessment was associated with whether individuals viewed themselves as spiritual ($p=.034$, chi-square analysis). Almost one third (31 %) of individuals who did not consider themselves spiritual stated they "seldom" or "never" referred patients to someone else for spiritual assessment, 54 % said "sometimes" while only 15 % said "always" or "most of the time." In contrast, 32 % of spiritual respondents referred patients to others, compared with 25 % who said they never referred patients. Of note, the majority of those who indicated they never referred patients conducted the spiritual care assessment actually conducted the assessments themselves.

There were other factors associated with whether respondents viewed themselves as spiritual. A larger proportion of respondents who did not consider themselves spiritual chose "none" when asked which spiritual practices they would choose for their patients ($p=.01$) and specifically not choosing healing touch as spiritual practice ($p=0.002$). The proportion of "nonspiritual" respondents who reported that they could not provide adequate spiritual care (82 %) was significantly higher than that of "spiritual" respondents (59 %; $p=0.001$).

Not surprisingly, the median ranking respondents who were not spiritual gave for the role of spiritual care in the total care of the cancer patient was 6.0 compared to a rating of 7.5 from respondents who considered themselves spiritual, $p<.001$ (analyzed by Mann–Whitney test).

Discussion

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

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

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

been adequately supported. Among high "religious copers," these differences resulted in higher end-of-life costs (US$6,533 vs US$2,276; p=0.005) [24].

The outcome of the MASCC survey was not intended to pursue a unidirectional opinion, but rather a wide range of responses for the possibility of integrating a "spiritual history dialogue" into daily medical practice. Altering life and chronic stress situations lead to questions that individuals might try to answer according to their own appraisal of the illness situation. The survey presented only a limited approximation of the complexity of "spirituality" among a diversity cohort of medical professionals.

Embracing and exploring one's spiritual side may be important in protecting care givers and physicians from burnout and compassion fatigue [25]. Additional training and guidance to help physicians introspect and self-reflect (similar to the meaning-based therapy [26] or dignity therapy [27] prescribed to patients) may be helpful on this quest.

Other researchers have suggested that a "clinical intervention that would increase [an oncologist's] level of spiritual awareness and his or her level of comfort associated with a personal perspective on death could help decrease the patients level of psychosocial distress" [28, 29]. The key may be that "Those who are more aware of their own spirituality will be better at recognizing, understanding and attending to their patients' needs" [30]. As one oncologist stated, "Knowing what is important to our patients, what they treasure and think is worth fighting for, and how they wish to be remembered helps guide the dialogue when we run out of treatment options" [31]. If physicians do not use spiritual, existential inquiry when asking patients about their history, it is improbable that they could expect to know their most deeply held beliefs.

Our study was not without potential limitations. One concern with the type of survey that we conduct is the potential selection bias of respondents, who tend to be those most interested in a positive or negative sense. Selection bias and language barriers can confound responses to questions of an emotional nature and thus affect responses and response rate. Lastly, because this was an international survey of MASCC of different countries and cultures, it is possible that some respondents assumed "spiritual" to mean "religious" and answered accordingly.

We developed this survey to better understand the practice and meaning of spiritual care for MASCC members. Ultimately, we hoped to provide a rationale for the need to develop culturally sensitive recommendations to provide guidance to supportive care professionals on how to start approaching spiritual care as part of their clinical practice. The results of our survey study indicate that although MASCC members feel that spiritual care is important, few have the training (or possibly desire) to assess and attend to their patients' spiritual needs. Although definitions of spirituality trend towards wide non-rigid concepts such as that formulated in 2009 by Puchalsky et al. (1) and the Canadian Palliative Care Association definition: "An existential construct inclusive of all the ways in which a person makes meaning and organizes his/her sense of self around a personal set of beliefs, values and relationships" [32], for some physicians, the concept may remain too ambiguous, obscure, and uncomfortable to discuss with patients.

Surprisingly, we learned that more time and effort must be invested to help MASCC members recognize the importance of their role in providing spiritual care and overcome barriers to assessing spiritual needs and providing spiritual care before guidelines for international spiritual care approaches can be developed.

Acknowledgments This research was supported in part by the National Institutes of Health through MD Anderson's Cancer Center Support grant CA016672.

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

Appendix

Survey questions

Q1. What is your definition of spiritual care in your practice? (please select two that best define it for you)

□ Alleviate spiritual/existential pain/suffering (42.4 %)

□ Offering emotional support as part of addressing psychosocial needs (49.8 %)

□ Helping patients' illness narrative and life review (10.3 %)

□ Helping patients examine and reconstruct their spiritual beliefs answering specific spiritual concerns (17.7 %)

□ Offering spiritual practices such as prayer (8.5 %)

□ Helping patients find meaning in life through various therapies (0 %)

Q2. "In your opinion, what is the role of spiritual care in the total care of the cancer patient? (Please rank on the scale below, 10 being the "most important", and 0 being "not at all")

Not at all									Most important	
0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

Q3. If you were to use spiritual practices which ones would you choose to use? (check all that apply)

□ Dignity therapy (27.7 %) □ Logo therapy (8.5 %)

□ Healing touch (24.4 %)

□ Yoga therapy (26.9 %)
□ Art therapy (29.5 %)
□ Music therapy (42.4 %)
□ Other (15.5 %)
□ None (13.3 %)
□ Other (please specify)_____

Q4. Do you think it is your role to explore the spiritual concerns of your cancer patients?
□ Yes (39 %)
□ No (12 %)
□ Sometimes (49 %)

Q5. In your own practice, if you do not conduct a spiritual assessment, do you refer patients to someone else for spiritual assessment?
□ Always (9.2 %)
□ Most of the time (18.5 %)
□ Sometimes (45.8 %)
□ Seldom (14.9 %)
□ Never (11.6 %)

Q6. When you refer patients, whom do you refer them to for the assessment?
□ Yourself (4.1 %)
□ Another physician (8.1 %)
□ Nurse (4.8 %)
□ Chaplain (43.2 %)
□ Volunteer (4.1 %)
□ Other (15.1 %)
□ Do not refer patients (12.5 %)
□ Other (please specify) _____

Q7. Check at which stage(s) it is most appropriate for a spiritual assessment to be done?
□ Soon after diagnosis (22.1 %)
□ During active treatment phase (6.6 %)
□ During survival phase (8.9 %)
□ During palliative care phase (17.7 %)
□ At the end-of-life (10.3 %)
□ Repeatedly throughout all illness trajectory (63.8 %)

Q8. Do you use a standardized spiritual questionnaire or is one used in your practice (at your hospital)?
□ Yes (9.6 %)
□ No (90.4 %)
□ Comment _____

Q9. If you answered "yes" to Question 14, which one(s)? (Check all that apply)
□ FICA (4.4 %)
□ SPIRIT (1.1 %)
□ HOPE (1.5 %)
□ SBI-15R (1.8 %)
□ FACIT-Sp (2.6 %)
□ Other (please specify) _____

Q10. At this point in your life, are you pursuing any active personal spiritual inquiry? (Check all that apply)
□ Reading books on spirituality (31.7 %)
□ Contemplation (22.5 %)
□ Spiritual practice (26.2 %)
□ Spiritual support group (5.9 %)
□ Not pursuing any active personal spiritual inquiry (39.5 %)
□ Other (please specify) _____

Q11. In the past 2 years have you pursued any spiritual training to help you in providing spiritual care for cancer patients?
□ Yes (20 %) Other (please specify) _____
□ No (80 %)

Q12. If you answered "yes" to Question 17, please check from the list below those that you have pursued to help you in providing spiritual care for your patients? (Check all that apply)
□ Reading books on spirituality (15.5 %)
□ Contemplation (5.5 %)
□ Spiritual practice (6.6 %)
□ Seminar on spirituality (11.1 %)
□ Other (please specify) _____

Q13. In your opinion, can you adequately provide spiritual care?
□ Yes (2.8 %)
□ Most of the time (32.5 %)
□ Seldom (36.5 %)
□ No (28.1 %)

Q14. Please check all that you feel keeps you and others from providing spiritual care? (Check all that apply)
□ Need more training (50.6 %)
□ Need to refer to specialist (21 %)
□ Prefer to refer to chaplaincy (28.8 %)
□ Not enough time (37.3 %)
□ Not appropriate (21 %)

Q15. Have you ever had any kind of training or education regarding spiritual care?
□ Yes (29.5 %) □ If yes, please describe the training _____
□ No (70.5 %)

Q16. In your opinion which tools, training, or education are most necessary in order to offer spiritual care? (check all that apply)
□ Training or education in basic communication skills (57.6 %)
□ Awareness of one's own beliefs (51.3 %)
□ Understanding of other world views (53.9 %)
□ Basic knowledge and skills in recognizing spiritual issues (70.1 %)
□ Knowledge of different religions and spiritual practices (59.8 %)
□ Consulting with a trained chaplain on staff (35.8 %)
□ Other (please specify) _____

Q17. Do you claim a religious category for yourself?

Yes (70.7 %)

No (29.3 %)

Q18. If you answered "yes" to the previous question, please indicate your religious category.

□ Buddhism/Hinduism (6.3 %)
□ Christianity – Catholic (22.9 %)
□ Christianity – Protestant (21.8 %)
□ Christianity – Orthodox (3.7 %)
□ Islam (3.3 %)
□ Judaism (4.1 %)
□ Other (3.3 %)
□ Answered "no" (26.2 %)
□ No answer (8.1 %)

Q19. Do you consider yourself a spiritual person?

□ Yes (75.5 %)

□ No (24.5 %)

References

1. Puchalski C, Ferrell B, Virani R et al (2009) Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. J Palliat Med 12:885–904
2. Chochinov HM, Cann BJ (2005) Interventions to enhance the spiritual aspects of dying. J Palliat Med 8(Suppl 1):S103–S115
3. Vallurupalli M, Lauderdale K, Balboni MJ et al (2012) The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. J Support Oncol 10:81–87
4. Puchalski CM, Dorff RE, Hendi IY (2004) Spirituality, religion, and healing in palliative care. Clin Geriatr Med 20:689–714, vi-vii
5. Pearce MJ, Coan AD, Herndon JE 2nd et al (2012) Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. Support Care Cancer 20:2269–2276
6. Hills JPJ, Cameron JR, Shott S (2005) Spirituality and distress in palliative care consultation. J Palliat Med 8:782–788
7. Boscaglia N, Clarke DM, Jobling TW, Quinn MA (2005) The contribution of spirituality and spiritual coping to anxiety and depression in women with a recent diagnosis of gynecological cancer. Int J Gynecol Cancer 15:755–761
8. Ramondetta L, Brown A, Richardson G et al (2011) Religious and spiritual beliefs of gynecologic oncologists may influence medical decision making. Int J Gynecol Cancer 21:573–581
9. Balboni TA, Paulk ME, Balboni MJ et al (2010) Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. J Clin Oncol 28:445–452
10. Cocconi G, Caminiti C, Zaninetta G et al (2010) National survey of medical choices in caring for terminally ill patients in Italy, a cross-sectional study. Tumori 96:122–130
11. Seal C (2010) The role of doctors' religious faith and ethnicity in taking ethically controversial decisions during end-of-life care. J Med Ethics. doi:10.1136/jme.2010.036194
12. Surbone A, Konishi T, Baider L (2011) Spirituality in cancer care. In: Olver I (ed) Cancer supportive care and survivorship. Springer, New York, pp 419–425
13. Survey Monkey (2010) www.SurveyMonkey.com. Accessed 2 Jan 2011
14. Moadel A, Morgan C, Fatone A et al (1999) Seeking meaning and hope: self-reported spiritual and existential needs among an ethnically-diverse cancer patient population. Psychooncology 8:378–385
15. Post SG, Puchalski CM, Larson DB (2000) Physicians and patient spirituality: professional boundaries, competency, and ethics. Ann Intern Med 132:578–583
16. Kafka F (1919) A country doctor. Twisted Spoon, Prague Czech Republic
17. Balboni TA, Vanderwerker LC, Block SD et al (2007) Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. J Clin Oncol 25:555–560
18. Vincent JL (1999) Forgoing life support in western European intensive care units: the results of an ethical questionnaire. Crit Care Med 27:1626–1633
19. Thune-Boyle IC, Stygall J, Keshtgar MR et al. (2012) Religious/spiritual coping resources and their relationship with adjustment in patients newly diagnosed with breast cancer in the UK. Psycho-Oncology. Published online (willeyonlinelibrary.com).
20. Kristeller JL, Sheets V, Johnson T, Frank B (2011) Understanding religious and spiritual influences on adjustment to cancer: individual patterns and differences. J Behav Med 34:550–561
21. Pargament KI, Zinnbauer BJ, Scott AB et al (1998) Red flags and religious coping: identifying some religious warning signs among people in crisis. J Clin Psychol 54:77–89
22. Lederberg MS, Fitchett G (1999) Can you measure a sunbeam with a ruler? Psychooncology 8:375–377
23. Astrow AB, Wexler A, Texeira K et al (2007) Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care? J Clin Oncol 25:5753–5757
24. Balboni T, Balboni M, Paulk ME et al (2011) Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. Cancer 117:5383–5391
25. Kearney MKWR, Vachon ML et al (2009) Self-care of physicians caring for patients at the end of life: "being connected.. a key to my survival". JAMA 301:1155–1164
26. Breitbart W, Rosenfeld B, Gibson C et al (2010) Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial. Psychooncology 19:21–28
27. Chochinov HM, Hack T, Hassard T et al (2005) Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. J Clin Oncol 23:5520–5525
28. Gioiella ME, Berkman B, Robinson M (1998) Spirituality and quality of life in gynecologic oncology patients. Cancer Pract 6:333–338
29. Seccareccia D, Brown JB (2009) Impact of spirituality on palliative care physicians: personally and professionally. J Palliat Med 12:805–809
30. Surbone A, Baider L (2010) The spiritual dimension of cancer care. Crit Rev Oncol Hematol 73:228–235
31. Schapira L (2008) Communication at the end of life. J Oncol Pract 4:54
32. Ferris FD, Balfour HM, Bowen K et al (2002) A model to guide patient and family care: based on nationally accepted principles and norms of practice. J Pain Symptom Manage 24:106–123