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Implementing Spiritual Care for Patients Receiving End-of-Life Palliative Care: A Mixed-Methods Systematic Review

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Abstract

Using the Theoretical Domains Framework (TDF), this systematic investigation aims to analyze and integrate current data on impediments and facilitators to integrating spiritual care within palliative programs for terminal populations. A comprehensive search was executed across six digital repositories (PubMed, Embase, CLNAHL, Web of Science, ProQuest, and the Cochrane Library) for literature published before July 2025. This review incorporated both qualitative and quantitative papers detailing how patients and clinical staff view the delivery of spiritual support at life's end. Methodological rigor was assessed using a mixed-methods appraisal tool. The extracted barriers and drivers were then mapped onto specific TDF categories using a blended deductive-inductive qualitative approach. The final analysis comprised 27 papers: 13 quantitative, 7 qualitative, and 7 mixed-method studies. Patient viewpoints were captured in 7 of these papers, whereas healthcare clinician perspectives were featured in 23. While factors aligned with most TDF domains, two distinct themes emerged outside the framework: "Providers' Spiritual Self-Care and Reflection" and "Provider-patient' Longitudinal relationships". The analysis yielded 16 distinct sub-themes for hindering factors and 16 for facilitating factors. Conversely, two TDF categories lacked any corresponding data: Memory, Attention, and Decision Process (for barriers) and Behavior Regulation (for enablers). This review outlines the key factors influencing the delivery of spiritual care to terminally ill patients. Truly embedding this care requires moving away from reactive "end-of-life spiritual rescue" toward a model of continuous spiritual care. Healthcare workers must see themselves as active behavioral change agents who can bridge latent patient vulnerabilities with perceived professional boundaries. Future policy should center on interdisciplinary schooling, embedding spiritual metrics directly into standard clinical records, and protecting structural continuity between clinicians and patients.

Keywords: Spiritual care, Palliative care, Systematic review, Theoretical domains framework

Introduction

Terminal patients contend not only with intense physical distress (such as pain and dyspnea) and psychological strain (including anxiety, depression, and fear), but also face profound, unmet existential and spiritual needs [1, 2]. When individuals in the final stages of a disease are deprived of spiritual guidance, they face a heightened vulnerability to psychological distress, a drop in overall quality of life, and a fractured sense of inner peace [3]. According to the 2020 World Health Organization (WHO) guidelines, palliative care aims to maximize the quality of life for patients and families navigating life-limiting illnesses. A core pillar of this methodology is early detection and absolute precision in managing distress—whether physical, psychosocial, or spiritual [4]. Palliative practices cannot claim to be truly holistic if they exclude spiritual elements from routine medical practice.

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Supporting this, individuals whose spiritual concerns are consistently ignored consistently report lower satisfaction with their medical teams [5].

Per the 2020 International Association for Palliative Care (IAHPC) updated terminology, spiritual care entails recognizing and addressing a person's inner needs when confronting serious sickness, mortality, bereavement, or existential questioning, ultimately guiding them toward discovering meaning, purpose, and value in life [6]. While this definition cuts through some of the field's historical conceptual ambiguity, major misconceptions remain. Chief among these is the incorrect assumption that spiritual care is merely shorthand for religious intervention or basic psychosocial counseling. In reality, it is a highly personalized, evolving practice that knits together patient welfare across seven foundational pillars: a healing presence, the intentional therapeutic use of self, intuitive understanding, spiritual exploration, a patient-centered focus, meaning-driven interventions, and an environment designed to nurture the spirit [7].

Even though contemporary research has yielded sharper screening instruments and targeted intervention frameworks, embedding spiritual care into real-world clinical workflows remains incredibly challenging. Frontline clinicians routinely express feeling overwhelmed by the intricate nature of this care [8-10], finding it highly difficult to adequately address the varied spiritual leanings of their patients [11, 12]. Methodically breaking down the specific variables that block or propel these interventions is vital to clearing obstacles, standardizing clinical execution, and elevating holistic care standards.

A past systematic review of 11 qualitative papers gathered the real-world experiences of specialized palliative nurses, showing that an individual nurse's spiritual grounding, life background, and clinical exposure to the dying process play a significant role in the delivery of spiritual care [13]. Similarly, a separate scoping review identified four macro-areas that determine implementation success: communication, education, religious factors, and the bond between nurse and patient [12]. However, these summaries relied almost entirely on the medical staff's outlook. Because patients and their loved ones often view hindrances and facilitators through entirely different lenses, a broader review that considers all parties is deeply necessary.

The Theoretical Domains Framework, originally introduced by Susan Michie and her team in 2005 and updated in 2012 (TDF-V2), offers an exceptional organizational and behavioral lens to study practice changes among professionals [14]. By synthesizing numerous independent theories on clinical behavior, the TDF provides an ideal structure for isolating underlying behavioral drivers and designing targeted implementation plans. Consequently, this systematic review seeks to collect primary studies from a wide array of stakeholders and index those insights directly onto the TDF to map out what stops or starts spiritual care practices for individuals facing terminal illnesses.

Materials and Methods

Protocol and registration

This systematic review was conducted and reported in accordance with the PRISMA 2020 reporting standards. The protocol was formally archived with PROSPERO in August 2025 under the registration index CRD420251120644.

Study design

The TDF is well-suited to qualitative analytical frameworks based on open-ended interviews and descriptive surveys. This project utilized a data-based convergent design to ensure a fully unified synthesis [15]. To achieve this, outcomes from diverse study methodologies underwent a process of "qualitizing"—meaning quantitative values and diverse findings were translated into descriptive narrative codes. This strategy paved the way for a smooth qualitative meta-synthesis, in which both data formats carried equal analytical weight in shaping the final themes. Following this step, all synthesized findings were deductively classified under their respective TDF categories.

Let's try a much more extensive transformation. This version completely restructures the sentences, replaces verbs with passive or alternative active forms, and rephrases the academic terminology, all while keeping your data points, numbers, names, and abbreviations (n = 24, RT and FL, MMAT, etc.) perfectly intact.

Inclusion criteria

To be eligible for selection, papers had to utilize qualitative, quantitative, or mixed-methods methodologies. Inclusion was strictly restricted to peer-reviewed, published academic literature. The research setting had to operate within a palliative care framework, zeroing in specifically on care delivered during the terminal phase of life. In the quantitative research, the eligibility criteria included variables related to perceived impediments and drivers of spiritual care integration. For qualitative research, inclusion required documenting viewpoints from patients, family caregivers, palliative medicine physicians, nurses, and other clinical professionals participating in spiritual interventions.

Exclusion criteria

Studies were omitted if they met any of the following parameters: (1) Papers presenting an ambiguous concept of spiritual care, including research where spirituality is merely noted in passing without an explicit operational framework or defined theoretical construct, (2) Projects executed outside established hospice or palliative environments, such as acute medical wards that lack dedicated palliative care protocols, (3) Academic work published in languages other than English, alongside gray literature, editorial pieces, correspondence, conference proceedings, case reviews, or abstracts that do not offer complete datasets, and (4) Investigations that omit concrete data or distinct thematic findings regarding the actual execution process of spiritual care.

Search strategy

Literature was gathered from six digital data repositories—PubMed, Embase, CLNAHL, Web of Science, ProQuest, and the Cochrane Library—filtering for items published before July 2025. Furthermore, the bibliography lists of relevant, contemporary literature reviews were manually cross-checked. The following search terms were deployed during the query stage: "spiritual*", "spiritual care", "spiritual comfort", "spiritual distress", "spiritual well-being", "spiritual support", "palliative care", "palliative", hospices", "hospice care", "terminal care", "end of life", "terminal", "terminally ill".

Selection process

The compiled search outputs were transferred into EndNote X9 reference management software. Once duplicate entries were purged, two independent assessors (RT and FL) performed an initial screening of titles and abstracts using the web tool Rayyan to determine suitability. Finally, the full text of the remaining manuscripts was scrutinized to assemble the definitive cohort of papers for inclusion.

Quality assessment

Methodological quality was appraised independently by two investigators (RT and FL) utilizing the 2018 edition of the Mixed-Methods Appraisal Tool (MMAT) [16]. The selection of the MMAT stems from its capacity to evaluate the validity of all three distinct study formats (qualitative, quantitative, and mixed-methods). Because the formal MMAT guidelines do not support dropping papers based on lower methodological scores, no papers were rejected based on the quality evaluation results.

Data extraction

The architecture of the extraction template was guided by the Standards for Reporting Qualitative Research (SRQR) alongside the Quantitative Data Extraction Template from the Cochrane Consumers and Communication Group [17]. Two investigators (RT and FL) completed a preliminary pilot test of this extraction sheet using one qualitative, one quantitative, and one mixed-methods paper. Following this, a single investigator (RT) populated the validated template with data from the full text of all included papers. A secondary investigator (FL) then scrutinized the extracted records to verify data fidelity. The compiled records comprised direct quotes from qualitative participants, themes underlying the delivery of spiritual care, statistical outcomes from questionnaires or surveys, and the authors' conclusions. For quantitative papers (whether observational or interventional), variables and predictors linked to the implementation of spiritual care were also isolated. Additional **Table 1** hosts the finalized data extraction template.

Framework coding and thematic synthesis

The initial code assignment was carried out independently by two researchers (RT and FL), who received explicit training in TDF methodologies. These codes were subsequently reviewed by a wider authorship panel: SW, FZ, JL, CP, YH, and XY. Any analytical disagreements were discussed and reconciled collectively during group meetings. Ultimately, the team worked in tandem to establish overarching themes that characterized the entire dataset. Following the deductive indexing of data into TDF categories, an inductive thematic synthesis was executed to capture any remaining records not fully covered or explained by the preset TDF domains.

Results and Discussion

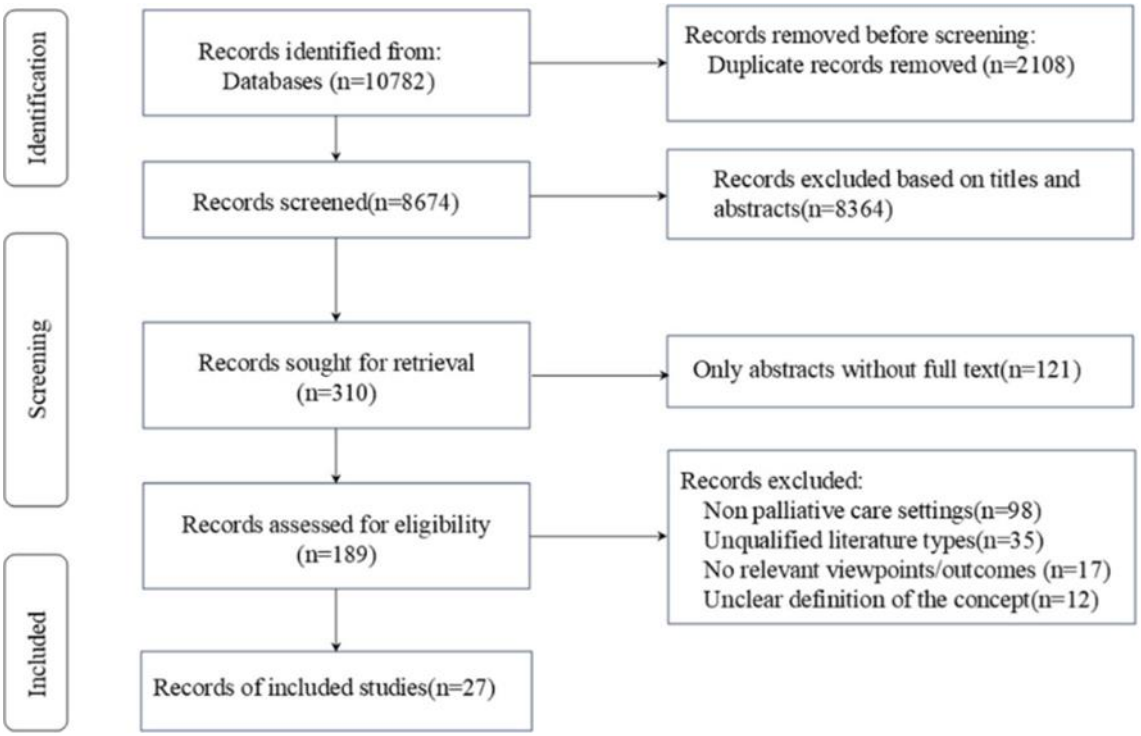

Figure 1. The flow chart of literature selection

In total, 8674 papers (after removing duplicates) were screened at the title and abstract, and 310 papers at full text. 283 were excluded for failing to meet the established inclusion and exclusion criteria. Ultimately, 27 studies were included in the analysis. Further details are provided in **Figure 1**.

Study characteristics

The final pool consisted of 27 papers, divided into 7 quantitative, 13 qualitative, and 7 mixed-methods research designs. Patient insights were featured in 7 papers, the perspectives of clinical staff were captured in 23, and a single study additionally incorporated the viewpoints of family caregivers. The involved medical personnel spanned palliative specialists, primary care practitioners, oncologists, registered nurses, general practitioners, nursing assistants, and administrative personnel.

In terms of methodology, observational strategies predominated (n = 24), utilizing qualitative focus groups or personal interviews (n = 7), quantitative cohort designs or surveys (n = 10), and integrated mixed-methods structures (n = 7). Conversely, interventional frameworks were limited (n = 3), comprising two randomized controlled trials and one quasi-experimental pretest–posttest study. Geographically, the research originated primarily from the USA (n = 6), Australia (n = 4), the Netherlands (n = 3), and the UK (n = 2), with supplemental data from nations across Europe, Asia, and North America **(Table 1)**. Two multi-country studies broadened this distribution: one qualitative paper collected data across 11 nations (including South Africa, Kenya, and Canada), while another deployed cross-sectional assessments across Türkiye, Albania, and Italy. Methodological rigor across the bulk of the included papers was designated as “good”.

Table 1. Overview of the included studies, key findings, and corresponding Theoretical Domains Framework (TDF) domains. From: Barriers and enablers of implementing spiritual care at the end of life: A mixed-methods systematic review based on the Theoretical Domains Framework.

Reference	Country	Study design	Participants	Measures/Themes investigated	Key findings
Abusafia *et al.* [18]	Malaysia	Quantitative	122 nurses (intervention group = 59; control group = 63)	Randomized controlled trial (RCT); Spiritual Care Competence Scale (SCCS); examined the effectiveness of the Nursing Spiritual Care Module in improving nurses’ spiritual care competence in Malaysia	Facilitator: Participation in the training program significantly enhanced spiritual care competence. Pairwise comparison analysis demonstrated a significant pre–post improvement in the intervention group (mean difference = 5.569, 95% CI: 2.818–8.320; P = .001). Additionally, the intervention group achieved significantly higher spiritual care competence scores than the control group (P = .001).

Anandarajah *et al.* [19]	United States	Qualitative	34 physicians	Longitudinal semi-structured interviews; explored factors affecting physicians' ability to provide spiritual care over time	Themes: Patients' spiritual needs and commitment to holistic care remained key motivators. Training in cross-cultural spiritual care communication reduced physicians' influence from their personal spiritual beliefs and concerns. Life experiences strengthened spiritual care abilities. Workplace environments either supported or impeded the delivery of spiritual care. Personal spiritual reflection and self-care promoted compassionate, patient-centered care.
Bailey *et al.* [20]	Ireland	Qualitative	22 palliative care nurses	Semi-structured interviews; explored nurses' experiences of providing spiritual support in palliative care settings	Facilitators: Development of trusting nurse–patient relationships, professional experience, intuition, and the practice of "being with" patients. Barriers: Limited time for meaningful presence within organizational constraints and challenges in assessing and measuring spiritual care outcomes.
Balboni *et al.* [21]	United States	Quantitative	75 patients, 339 nurses and physicians	Questionnaires, including the Multidimensional Measure of Religiousness and Spirituality and researcher-developed scales; examined factors associated with infrequent spiritual care provision at the end of life	Barriers: Insufficient time was commonly reported by both nurses (71%) and physicians (73%) (P = .39). Facilitators: Previous spiritual care training significantly increased spiritual care provision among nurses (OR = 11.20, 95% CI: 1.24–101) and physicians (OR = 7.22, 95% CI: 1.91–27.30). Higher intrinsic religiosity predicted greater provision among nurses (β = 3.47, P = .02), while greater physician spirituality was associated with increased provision among physicians (β = 4.64, P = .001).
Balboni *et al.* [8]	United States	Quantitative	339 nurses and physicians	Questionnaires using the Multidimensional Measure of Religiousness and Spirituality and researcher-developed measures; investigated clinicians' desire to provide spiritual care, and evaluated 11 potential barriers	Barriers: Nurses identified a lack of private space as a major obstacle, whereas physicians highlighted insufficient time. Factors associated with less frequent spiritual care provision included inadequate training, perceptions that spiritual care was outside one's professional role, and concerns about power imbalances between clinicians and patients.
Bar-Sela *et al.* [22]	Middle East	Quantitative	770 oncology staff members (39% physicians, 59% nurses)	Researcher-developed questionnaire; examined barriers to spiritual care provision in a Middle Eastern oncology setting	Perceived Barriers: Lack of time (66%), inadequate private space (58%), and insufficient training (54%). Barriers to Actual Provision: Lower personal spirituality (P < .001) and absence of spiritual care training (P = .02) were associated with reduced spiritual care delivery.
Baysal *et al.* [23]	Türkiye, Albania, and Italy	Quantitative	1,090 nurses	Questionnaires using the Spirituality and Spiritual Care Rating Scale (SSCRS); assessed nurses' perceptions of spirituality and spiritual care and factors influencing these perceptions	Barrier: Perception that the healthcare team did not appreciate nurses' spiritual care efforts (35%). Facilitators: Receiving education on spiritual care, using spiritual practices to manage illness or difficulties, and believing in the therapeutic benefits of spiritual care practices.
Best *et al.* [24]	Australia	Qualitative	15 patients	Grounded theory and semi-structured interviews; explored the nature of spiritual support for cancer patients and their preferences for spiritual care from physicians	Themes: Sources of spiritual support that helped patients manage illness and address spiritual needs, factors facilitating spiritual support, and the physician's role in providing spiritual support.

Best *et al.* [25]	Australia	Quantitative	175 patients with advanced cancer	Randomized controlled trial (RCT); examined the frequency and content of spirituality discussions, the impact of a Question Prompt List (QPL), and predictors of spiritual discussions	Facilitators: Receiving a QPL, attending a first palliative care consultation, and being directly asked about concerns by a physician increased the likelihood of spirituality-related discussions.
Chahrour *et al.* [26]	Denmark	Mixed-methods	Staff from two hospices, including healthcare professionals, service assistants, and administrative personnel (15 interview participants; 57 questionnaire respondents)	Focus group interviews and questionnaires using researcher-developed scales and open-ended questions; explored barriers to spiritual care and evaluated the impact of spiritual care training	Barriers: Absence of a common, adequate spiritual vocabulary; overlap between patients' physical and existential concerns; and limited provider self-reflection, self-awareness, introspection, and vulnerability. Facilitator: Participation in spiritual care training programs.
Fradelos *et al.* [27]	Greece	Mixed-methods	Focus groups: 3 nurses and 2 nursing assistants; Questionnaire survey: 275 nurses and nursing assistants	Focus group discussions and questionnaires (FACIT-Sp-12, SCIPS, NEO-FFI, and SCS); explored factors shaping nurses' beliefs regarding the provision of spiritual care	Themes: Spiritual care was perceived as a vocation; communication skills were essential for effective care; cultural barriers needed to be addressed; and spiritual growth was linked to compassion satisfaction. Barrier: Employment in outpatient departments was associated with reduced engagement in spiritual care. Facilitators: A supportive spiritual climate in the workplace and specialization in palliative care promoted the provision of spiritual care.
Geer *et al.* [28]	Netherlands	Quantitative	244 healthcare professionals, including 214 nurses and 41 physicians	Quasi-experimental pretest–posttest study using the SCCS and SAIL; evaluated the impact of a spiritual care training program in palliative care and examined spiritual care barriers and competencies among healthcare professionals	Facilitator: A brief, practice-oriented training program delivered within a manageable timeframe of 90–180 minutes was found to support the development of spiritual care competencies among hospital staff.
Green *et al.* [29]	United States	Mixed-methods	391 registered nurses (RNs)	Questionnaires, including Part II of the SCP, SCC, NSCT, and open-ended questions; investigated nurses' perceptions of spiritual care competence, preparedness, and barriers to spiritual care delivery	Barriers: Lack of time was the most frequently reported obstacle (Rank 1, n = 42, 26.1%), followed by lack of support (Rank 2, n = 30, 18.6%), insufficient knowledge (Rank 3, n = 21, 13.0%), and discomfort with providing spiritual care (Rank 4, n = 16, 9.9%). Facilitators Included Participation in spiritual care education, greater self-reported preparedness, more frequent involvement in spiritual care activities, and longer clinical experience, all of which were associated with improved spiritual care provision.
Holmes *et al.* [30]	United States	Quantitative	65 patients with end-stage illness and 67 primary care physicians (PCPs)	Researcher-developed questionnaire; examined the spiritual concerns of seriously ill patients and the spiritual care practices of PCPs	Patient-Reported Barriers: Many patients believed spiritual care was not part of the physician's role (63%), felt their PCP lacked sufficient time (31%), or assumed their PCP would not wish to discuss spiritual matters (17%). Physician-Reported Barriers: Lack of time was the most commonly cited obstacle (82%), followed by feeling inadequately competent (37%) and perceiving spiritual

					care as outside their professional responsibilities (21%).
Kang *et al.* [31]	South Korea	Mixed-methods	282 nurses and 6 hospice and palliative care (HPC) experts	Focus group interviews with 6 HPC experts, questionnaires assessing spiritual care competence (SCC), and open-ended questions; explored nurses' perceptions of spiritual care and their competence in delivering it	Facilitators: Completion of hospice care training was significantly associated with spiritual care competence (β = -0.190, P = .003), while hospice care experience also had a positive influence (β = 0.158, P = .015). Themes: The need for standardized terminology in spiritual care, clinically applicable spiritual care education, and evidence-based clinical guidelines for spiritual care interventions. Barriers: Limited understanding of spiritual care and insufficient ability to implement it; lack of time due to heavy workloads, which restricted attention to both patients' and nurses' spirituality; and inadequate personal spiritual reflection among nurses.
Keall *et al.* [32]	Australia	Qualitative	20 palliative care nurses	Semi-structured interviews; explored the facilitators, barriers, and strategies identified by Australian palliative care nurses when providing existential and spiritual care to patients with life-limiting conditions	Facilitators: Establishing strong nurse–patient relationships (14/20 nurses) and effective communication skills (13/20 nurses) were considered important for delivering spiritual care. Barriers: Insufficient time, limited skills, and lack of privacy were commonly reported (11/20 nurses). Additional obstacles included fear of uncovering difficult issues (7/20), unresolved patient symptoms (4/20), and differences in cultural or religious beliefs.
Kiaei *et al.* [10]	Iran	Mixed-methods	259 nurses	Questionnaires using the SSCRS and open-ended questions; examined Iranian nurses' perceptions of spiritual care and the barriers they encountered in practice	Major Themes: Inadequate education and training related to spiritual care, and organizational barriers that hindered its provision. Facilitator: Higher educational attainment was associated with more positive perceptions and implementation of spiritual care.
Koper *et al.* [33]	Netherlands	Mixed-methods	31 spiritual caregivers	An online focus group involving 9 spiritual caregivers and an online questionnaire with structured and open-ended items; investigated reasons for the limited involvement of spiritual caregivers in primary palliative care and explored strategies for improvement	Barriers: Lack of stable funding mechanisms, insufficient understanding of spiritual care among other healthcare professionals, and delayed involvement of spiritual caregivers in patient care. Facilitators: Effective communication with healthcare professionals, strong trust-based relationships with patients, and open communication with patients themselves.
Laranjeira *et al.* [9]	Portugal	Quantitative	251 professionals registered with the Portuguese Association of Palliative Care	Questionnaires using the PBSC; assessed participants' perceptions of previously identified barriers to spiritual care	Barriers: Delayed referral to palliative care services (78.1%), excessive workload (75.3%), and uncontrolled physical symptoms (72.5%). Facilitator: Advanced education in spirituality and spiritual care intervention strategies was identified as a key enabling factor.
Li *et al.* [34]	China	Quantitative	372 nurses	Questionnaires, including the SCCS and the Perceived Professional Benefits Questionnaire; investigated nurses' spiritual care competence and its relationship with perceived professional benefits	Facilitators: Greater perceived professional benefits and participation in professional training programs were associated with higher levels of spiritual care competence.

Meepraser tsagool *et al*. [35]	Thailand	Qualitative	20 experts from palliative care, religious studies, and social work	Semi-structured interviews; explored potential models and future directions for spiritual care within palliative care settings	Themes: Development of spirituality training programs, identification of appropriate spiritual care providers, integration of spiritual care into healthcare systems, promotion of research and evidence-based practice, interdisciplinary collaboration, and transformation of care systems to better support spiritual care.
O'Brien *et al*. [36]	England	Qualitative	21 generalist and specialist nurses and healthcare professionals	Face-to-face semi-structured interviews; explored healthcare professionals' perceptions of spiritual care	Themes: Recognition of spirituality and provision of support for patients' spiritual needs. Facilitators: Understanding the significance of spiritual care and possessing effective communication skills were viewed as essential for successful spiritual care delivery.
Phelps *et al*. [37]	United States	Mixed-methods	Interviews: 75 patients with advanced cancer; Questionnaires: 339 oncology physicians and nurses	Face-to-face semi-structured interviews and questionnaires using the Fetzer Multidimensional Measure of Religiousness/Spirituality and eight spiritual care survey questions; examined perceptions of spiritual care among patients, physicians, and nurses	Themes: Positive impacts of spiritual care on patients, attitudes toward spiritual care, and characteristics of appropriate spiritual care delivery. Barrier: Conflicts regarding professional roles in providing spiritual care. Facilitators: Previous spiritual care experiences (AOR = 14.65, 95% CI: 1.51–142.23), higher levels of education (AOR = 1.26, 95% CI: 1.06–1.49), and religious coping strategies (AOR = 4.79, 95% CI: 1.40–16.42) were associated with greater spiritual care provision.
Rodin *et al*. [38]	Canada	Quantitative	204 oncology physicians and 118 oncology nurses	Researcher-developed questionnaire; investigated how oncology physicians and nurses perceived their role in spiritual care, factors influencing these perceptions, and the impact on spiritual care provision	Barrier: Most participants believed that spiritual care should primarily be provided by professional hospital chaplains (96% of physicians and 98% of nurses) or by patients' own spiritual communities (96% for both groups). Facilitator: Participation in spiritual care training was associated with greater involvement in spiritual care activities.
Ronaldson *et al*. [39]	Australia	Quantitative	42 palliative care registered nurses (RNs) and 50 acute care RNs	Questionnaires using the Spiritual Perspective Scale (SPS) and Spiritual Care Perspectives Questionnaire (SCPQ); examined the relationship between nurses' spiritual perspectives and their provision of spiritual care, as well as perceived barriers to spiritual caring	Barriers: Limited time availability and concerns regarding patient privacy were identified as major obstacles to providing spiritual care.
Selman *et al*. [40]	South Africa, Kenya, South Korea, the United States, Canada, the United Kingdom, Belgium, Finland, and Poland	Qualitative	74 patients and 71 family caregivers	Two focus groups at each study site (one patient group and one caregiver group); explored spiritual care needs, experiences, preferences, and research priorities among individuals with life-limiting illnesses and their caregivers across multiple countries	Themes: Patients' and caregivers' spiritual concerns; perceptions of spirituality and its significance during illness; experiences and opinions regarding spiritual care; preferences for spiritual care delivery; and priorities for future research. Barriers: Staff members' tendency to give spiritual care low priority and to provide it with insufficient time. Facilitators: Establishing meaningful human connections by prioritizing patients, making additional efforts, maintaining reliability and presence, and viewing spiritual care as an integral component of healthcare. Participants also highlighted the importance of developing educational interventions for healthcare staff.

Van der Steen *et al.* [41]	Netherlands	Quantitative	207 patients with dementia	Prospective study assessing patients' conditions 8 weeks after admission and the spiritual end-of-life care received before death; investigated predictors of spiritual end-of-life care provision as perceived by coordinating physicians	Independent Predictors of Spiritual End-of-Life Care: Greater family satisfaction with physician communication at baseline was associated with increased spiritual care provision (OR = 1.6, CI: 1.0–2.5 per 1-point increase on a 0–3 scale). Spiritual care was also more likely when faith or spirituality was considered highly important to the resident, regardless of whether it was important to the physician (OR = 19, CI: 5.6–63) or not (OR = 15, CI: 5.1–47).

1. Hospice palliative care HPC, Question prompt lists QPL, Chronic Illness Therapy-Spiritual Well-Being 12 scale FACIT-Sp-12, Spiritual Attitude and Involvement SAIL, Spiritual Care Intervention and Spiritual Well-Being questionnaire SCIPS, NEO Five-Factor Inventory NEO-FFI, Spiritual Climate scale SCS, Spiritual Care Practice questionnaire SCP, Spiritual Care Competency scale SCC/SCCS, Nurses' Spiritual Care Therapeutics scale NSCT, Spirituality and Spiritual Care Rating Scale SSCRS, Perceived barriers to spiritual care tool PBSC, Primary care physicians PCPs, Registered nurses RNs, Spiritual Care Practice Questionnaire SCPQ, Spiritual Perspective scale SPS

Identified barriers and enablers

The thematic coding revealed both impediments and facilitators across 12 of the 14 total TDF domains. No applicable data points on barriers or drivers could be mapped to the domains of Memory, Attention and Decision Process, or Behavior Regulation. This demonstrates that, across the collected literature on executing end-of-life spiritual care, these specific behavioral constructs were not major factors shaping stakeholder actions. Moving beyond this deductive framework, the inductive analysis surfaced two supplementary themes: "Providers' Spiritual Self-Care and Reflection" and "Provider-patient' Longitudinal relationships". The distribution of these variables across individual papers and domains is outlined in **Table 1**.

Let's elevate the language to make it much more distinct from the original text while strictly maintaining your structure, citations, and numbers. I have pushed the vocabulary further toward high-level academic prose to ensure a complete paraphrase.

Knowledge

Within the domain of knowledge, two distinct impediments to stakeholder comprehension of Spiritual Care were identified: first, the absence of formal preparatory training among healthcare professionals, and second, the cognitive difficulty patients encounter when attempting to conceptualize or define this type of care. A clinical survey of registered nurses found that a substantial majority (59.4%) had received no instruction on spiritual modalities during their pre-licensure academic curricula [29]. This pedagogical deficit represents a primary structural obstacle hindering the integration of Spiritual Care into standard clinical operations [29, 39].

We did not have any specific courses on spirituality or spiritual care in either our university curriculum or our workplace. Interview of a Nurse [10]

The construct of "spirituality" is frequently interpreted as an elusive, deeply individualized phenomenon that is difficult to untangle from conventional religion [7]. This conceptual fluidity is mirrored in patient narratives, in which individuals express ambiguity about the semantic boundaries of the term and struggle to dissociate it from traditional religious dogma [40]. Consequently, the absence of an explicit, consensus-based definition across stakeholder groups imposes a foundational hurdle for the initiation and custom calibration of spiritual interventions.

Skills

Regarding the skill-based domain, the analysis revealed one negative constraint and one enabling factor linked to clinical practice. Owing to a lack of formalized clinical protocols and a unified spiritual vocabulary, nursing staff frequently report depressed levels of professional self-efficacy when tasked with addressing patient spirituality [10]. They face pronounced difficulties in quantifying spiritual care outcomes and navigating sensitive spiritual dialogues with patients and medical peers alike [20, 26]. Illustrating this point, one study found that nursing personnel rated their professional capacities lowest on indices evaluating "professionalization and improving the quality of spiritual care" and "assessment and implementation of spiritual care" [29].

Conversely, an absolute consensus among respondents underscored that highly developed communication competencies are indispensable for the delivery of spiritual care [27, 32, 36]. The core components of this clinical skillset involve active listening techniques, the deliberate and comfortable deployment of silence, authentic expressions of empathy, and a highly attuned sensitivity to somatic and nonverbal behavioral markers [32].

Furthermore, longitudinal qualitative data suggested that the spiritual care proficiencies of medical practitioners are heavily dictated by their personal trajectories [19]. Profound, transformative life events—including parenthood, international immersion, familial illness or bereavement, and personal medical crises—were shown to markedly enrich a physician's capacity to administer spiritual support [19].

Social, professional role, and identity

This conceptual domain maps the professional and personal boundaries of spiritual care as envisioned by physicians, nurses, and patients. A triad of studies documented perspectives from a subset of physicians who viewed spiritual interventions as completely external to their core medical mandates [30, 37, 38]. In stark contrast, nursing staff demonstrated a much stronger alignment with this responsibility, uniformly describing spirituality as an intrinsic and foundational element of holistic nursing practice [20]. From the consumer perspective, data indicated that 62% of patients did not view spiritual care as within a physician's professional jurisdiction, 31% believed their primary care doctor lacked adequate scheduling availability, and 17% anticipated a lack of willingness on the part of their doctor to engage in such conversations [30]. These pessimistic patient expectations create systemic barriers to discussing spiritual anxieties with primary medical providers. Conversely, patients uniformly identified nursing staff as the ideal conduits for receiving spiritual intervention.

The nurses… because they are the people we have the most contact with. And we see them every day and easily talk with them. Focus group of patients [40].

Beliefs about capabilities

Beliefs about capabilities encompass the subjective self-appraisals of competence among healthcare clinicians alongside the interpersonal dynamics that complicate care delivery. Two specific sub-themes were categorized as barriers: professional self-doubt and patient-side skepticism. Both physicians and nursing staff characterized the execution of spiritual care—and even the baseline initiation of related discourse—as highly problematic and fraught with difficulty [26, 31, 32].

It's not really our role to provide this care. We're not trained in it, and others are available who would be better. Interview of a Doctor [37].

Furthermore, a distinct lack of patient confidence in a physician's specialized training in this arena can actively stifle meaningful spiritual dialogue [37].

I don't think most doctors have a background or education in religion or spirituality. I don't think that's why patients seek them out. Interview of a patient [37].

Optimism

Within this framework, Optimism is defined as a stakeholder's overarching positive orientation and the constructive expectation that spiritual interventions will yield therapeutic value. The sanguine expectations of both clinicians and patients act as vital catalysts for institutional implementation. For instance, 74.5% of surveyed nursing professionals maintained a fundamental conviction regarding the therapeutic and restorative efficacy of spiritual care methodologies [23]. This signals a widespread professional paradigm wherein addressing unresolved spiritual distress is viewed as a mechanism to mitigate somatic symptoms that have proven intractable to standard biomedical treatments.

Because your spiritual and your psychological needs can have a massive effect on your symptoms and your anxiety, and it can come out as physical, and if you can address somebody's spiritual needs, that might help them physically. Interview of a District Nurse [36].

Corroborating this, patients view spiritual and psychological care as uniquely advantageous in scenarios where medical and nursing staff can no longer offer biological remediation for physical pain [37].

Beliefs about consequences

In contrast, the domain of Beliefs about Consequences isolates the specific, anticipated clinical outcomes resulting from an intervention. This analysis generated three distinct sub-themes. First, a shared recognition of the therapeutic utility of spiritual care among physicians, nurses, and patients served as a major driver for its adoption [27, 37]. Conversely, a subset of stakeholders harbored deep-seated anxieties that spiritual intervention could precipitate deleterious outcomes, including escalating patient emotional distress, breaching personal boundaries, or inducing professional awkwardness [37]. These apprehensions directly suppressed clinical willingness to engage in such practices. To illustrate, 15.7% of medical practitioners and 17.6% of patients worried that introducing standardized spiritual care might inadvertently signal that all viable biomedical options had been exhausted [37]. Furthermore, nursing personnel expressed significant anxiety that these practices would exacerbate existing labor burdens. This perceived structural barrier not only fosters personal reluctance but also drives them to actively dissuade peers from providing such care [10, 27].

Some colleagues have told me that you are 'ruining the market', 'don't be so busy', because if they come again and again, they will demand more from us. Interview of a Surgical nurse [27].

Reinforcement

This final domain organizes the motivational drivers and behavioral incentives governing the provision or acceptance of spiritual care. Three explicit sub-themes emerged: "perceived benefit" as an enhancer, and "perceived negative effect" and "increase in care burden" as deterrents. A primary systemic barrier identified was

the complete absence of institutional reward mechanisms, which substantially de-incentivize nursing staff [10]. Conversely, when clinicians extract intrinsic professional gratification from spiritual care duties, their motivation to deliver these services escalates markedly [27, 34]. Finally, a patient's historical receipt of spiritual support was significantly correlated with an open and favorable stance toward standardized spiritual care delivery [37], demonstrating that positive prior exposure fundamentally increases patient receptivity and diminishes behavioral resistance.

Intention

Within the behavioral construct of intention, data were consolidated regarding the baseline disposition of key stakeholders toward participating in spiritual interventions. The analysis highlighted two facilitators: the professional readiness of healthcare practitioners to provide such support, and the concurrent receptivity of patients to engage in dialogues centered on spiritual matters. Crucially, individuals whose attending physicians actively enquired about spiritual anxieties were 4.04 times more likely to engage in spiritual dialogue than their counterparts who were not explicitly approached about the subject [25].

I believe that by acknowledging that every individual has a certain level of spiritual need, a clinician naturally monitors it with the same diligence applied to identifying somatic symptoms during each patient consultation. Interview of an Oncology Doctor [36].

Goals

Positioning spirituality as a foundational objective within palliative treatment protocols represents a powerful systemic catalyst for the execution of spiritual care [19, 20, 41].

It is central to our work, positioned near the top of the priority list—exceeding pharmaceutical interventions and even the primary roles of doctors or nurses. I am convinced that if patients can achieve spiritual peace, clinicians have cleared three-quarters of the path toward total comfort during the palliative stage. Interview of a registered general nurse in palliative care [20].

Concurrently, patients conceptualize spiritual interventions as a vital means of cultivating psychological hope in the final life stages [21, 37, 40]. This cognitive appraisal heightens their acceptance and valuation of spiritual modalities, potentially prompting them to proactively request such clinical services.

Environmental context and resources

The institutional environment and available material assets exert a profound influence over stakeholder actions regarding the integration of spiritual care. A thematic analysis of this domain identified five distinct sub-themes, with excessive clinical workloads as the most imposing barrier and previous educational instruction in spiritual care as the most critical enabler. Four separate investigations consistently confirmed that inadequate instructional preparation represents a primary structural obstacle preventing effective care delivery [8, 10, 31, 32].

A subset of the nursing staff experiences profound unease when navigating inquiries in these domains, primarily because they perceive their formal training as insufficient. Interview of a palliative care nurse [32].

Nursing professionals who had undergone dedicated spiritual care training exhibited significantly more sophisticated conceptualizations of spirituality and holistic care [23]. Even brief educational modules were shown to optimize nursing proficiencies across a spectrum of professional domains: clinical assessment and the delivery of spiritual care; professionalization and continuous quality improvement; personal coping support alongside patient counseling; and appropriate clinical referrals to specialized chaplaincy professionals [28].

Conversely, physicians and nursing staff frequently reported that their standard diagnostic and therapeutic obligations are excessively demanding, leaving them with little time and depleted energy reserves to devote to patients' spiritual needs.

A clinician might witness that fleeting window where a patient's vulnerability shows... yet you are simultaneously compelled to attend to six competing clinical tasks, making the preservation of that balance within a high-velocity ward exceptionally difficult. Interview of a palliative care nurse [32].

Socio-cultural differences and a systemic lack of environmental privacy introduce significant barriers for both healthcare clinicians and patients [22, 24, 32, 36]. The underlying anxiety of inadvertently offending in sensitive cultural paradigms often leads to clinical hesitation.

Because the potential to offend is exceptionally high, particularly within specific cultural frameworks and theological traditions facing the prospect of mortality, where precise customs dictate what is permitted and what is strictly forbidden. Interview of a Specialist Palliative Care Nurse [36]

In instances involving spouses, individuals tend to be reluctant to speak candidly in the presence of their partner. Furthermore, the sheer volume of personnel present—including the Registrar, the Consultant, and, recently, an attached medical student—makes achieving the necessary privacy extremely difficult. Interview of a palliative care nurse [36]

Importantly, the aforementioned logistical barriers predominantly reflect individual clinician viewpoints. From a macro-analytical perspective, the most formidable obstacle to widespread adoption of spiritual care was the

systematic failure of the broader multi-disciplinary healthcare team to validate and value the spiritual care contributions of nursing staff [23].

Social influences

Within the domain of social influences, which evaluates the mechanisms through which peer groups shape stakeholder behaviors, the analysis identified one negative barrier and two positive enablers. From the nursing perspective, a primary impediment stems from a lack of mutual professional alignment and understanding among colleagues within acute ward environments [27, 39].

Conversely, two powerful enabling factors were identified: the clinician's capacity to maintain an authentic, fully grounded presence with patients, and the acknowledged value of active listening techniques, which numerous participants identified as foundational to efficacious spiritual intervention.

Simply ensuring that patients realize a clinician is genuinely present, aligned with their interests, and prepared to listen, converse, and support them through distressing moments—which are precisely the spaces where spiritual themes surface. Interview of a primary care residency [19].

An additional interpersonal asset is the active engagement and psychological backing of family units. Empirical research indicates that patients cohabitating with family members are more likely to engage in spiritual discourse with their physicians than patients living in isolation [25]. Family members are often the primary catalysts for conversations about spiritual dimensions.

Emotion

The manifestation of negative emotional responses among healthcare providers toward spiritual modalities constitutes a major impediment to the delivery of care. Participants detailed personal challenges in intellectualizing the concept itself, paired with underlying feelings of apprehension and psychological anxiety regarding its clinical delivery [19, 31, 36, 40]. Crucially, empirical data demonstrate that this specific anxiety tends to recede as clinicians accumulate practical clinical exposure and achieve greater professional maturity [19].

While nursing and medical personnel receive rudimentary education on spiritual care, deep-seated misgivings and underlying fears persist surrounding the practical implementation of this concept. Focus group interview of hospice palliative care nurses [31].

Additional themes

Providers' spiritual self-care and reflection

A robust body of literature indicates that a clinician's personal spiritual orientation and intrinsic religious convictions significantly dictate their understanding of spiritual modalities and their subjective capacity to administer them [9, 19, 21-23, 26]. Research specifically shows that nursing professionals who actively leverage spirituality to navigate personal adversity and health crises and maintain a firm belief in its therapeutic utility display heightened diagnostic sensitivity and clinical proficiency in delivering spiritual support [23].

In contrast, a deficit in personal spiritual reflexivity among healthcare practitioners constitutes a major barrier, hindering their capacity to offer meaningful spiritual comfort to others [22, 31].

If nurses remain disconnected from or blind to their own inner spirituality, they are unable to recognize it in the individuals they treat. We lack an understanding of our own spiritual dimensions, and we remain insensitive to the degree to which our own spirits are exhausted and depleted. Focus group interview of hospice palliative care nurses [31].

Provider–patient longitudinal relationships

Respondents emphasized that established, longitudinal clinical relationships with patients, coupled with accumulated interpersonal trust, significantly streamline the initiation of spiritual dialogues [19, 20]. Consequently, community-based medical practitioners demonstrate a heightened readiness to provide spiritual support, and structured ward environments are substantially more conducive to such care delivery than high-stress emergency departments [19, 39].

During initial clinical consultations, conversations do not encompass spiritual dimensions... It is only after cultivating a more robust, trusting relationship that patients feel sufficiently secure to introduce these highly personal facets of their lives. Interview of a primary care residency [19].

In this mixed-methods systematic review assessing the facilitators and impediments to the delivery of spiritual care in end-of-life environments, evidence from 27 studies was consolidated, mapping determinants within and beyond the boundaries of the Theoretical Domains Framework. In contrast to earlier reviews that focused solely on qualitative data gathered from healthcare practitioners, this inclusive investigation incorporated patients' perspectives, offering a deeper understanding of the behavioral drivers shaping clinical practice.

Aside from persistent impediments such as limited time and deficient training, the findings indicate that implementation breakdowns are primarily grounded in the TDF domains of Social/Professional Role and Identity, as well as Beliefs about Capabilities, rather than stemming from a basic knowledge deficit. Even though medical

professionals recognize the conceptual worth of spiritual care, a large proportion view it as outside their occupational boundaries, frequently delegating this duty entirely to chaplains or specialized teams [26, 30-32, 37, 38].

An intriguing paradox arises when examining the patient's viewpoint. Although 62% of patients do not view spiritual care as a component of a doctor's professional obligations, and many explicitly express skepticism about a physician's spiritual preparation, patients are 4.04 times more likely to participate in spiritual conversations when the doctor proactively initiates the dialogue [25]. This indicates that patients possess an underlying spiritual necessity that is often suppressed by their internal perceptions regarding the "Social/Professional Role" of the medical practitioner. When a doctor steps across this boundary by inquiring about spiritual matters, it acts as a compelling Social Influence that legitimizes the patient's existential anxieties. To make this actionable, instruments such as Question Prompt Lists (QPLs) have proven beneficial for boosting both the frequency and the comprehensiveness of these dialogues [25]. In the end, clinicians must understand that they serve as the behavioral trigger; the primary obstacle is not a lack of interest on the patient's part, but rather an inflexible interpretation of the clinician's own role, which only the clinician can overcome.

Even though spirituality is distinct from religion, personal religious observance frequently lays the groundwork for spiritual capability. While the ambiguous conceptualization of "spirituality" was categorized as a knowledge-based impediment (given that it complicates both evaluation and provision), the data indicate that its essence is not merely a lack of information. Specifically, nurses who regularly engage in religious practices exhibit heightened spiritual sensitivity [21, 23], an attribute that enables this ambiguity to serve as a facilitator. For these practitioners, the absence of a rigid definition does not obstruct care; rather, it encourages person-centered inquiry instead of inflexible clinical standardization. This dual nature underscores that advancing spiritual care requires a shift away from standardized definitions and toward the development of professional capacity to manage individual meaning.

The outcomes highlight a major contradiction regarding Beliefs about Consequences. While a large number of individuals find spiritual care advantageous when physical symptoms become unmanageable [27, 36, 37], approximately 17.6% of patients worry that turning toward spirituality indicates that medical interventions have failed [37]. To prevent it from being viewed as a "substitute for care" that provokes distress, spiritual care must be introduced early in the timeline as a "healing presence." Intervention frameworks ought to pivot away from "end-of-life spiritual rescue" toward longitudinal spiritual integration, separating spirituality from ideas of medical abandonment and anchoring it within holistic support throughout the entire palliative course.

Developing long-term relationships serves as a vital facilitator, encouraging "relational continuity" and creating a psychologically secure environment for existential vulnerability [19, 20]. Nevertheless, using China's contemporary healthcare system as a case in point, the high-volume, fragmented nature of short-term clinical encounters stands in direct opposition to relationship-centered care. Restructuring delivery frameworks to support relational continuity is an indispensable prerequisite for success.

Additionally, clinicians regularly report a lack of self-efficacy stemming from the shortage of structured protocols [10, 20, 31]. This issue is magnified by an inadequate "reward mechanism," characterized by a lack of institutional validation and the omission of spiritual care from performance evaluations. By converting spiritual care into trackable interventions within Electronic Medical Records (EMR), healthcare organizations can ensure these practices are not only allocated resources. Still, they are also officially reinforced as a fundamental clinical skill.

As highlighted in the European Association for Palliative Care (EAPC) white paper, education in spiritual care must span multiple disciplines [42]. Training initiatives should place a premium on communication skills, as these are critical for both starting and maintaining spiritual conversations [20, 27, 32, 36, 40]. Crucially, a practitioner's personal spiritual self-reflection heavily impacts their capacity to provide care [9, 19, 22, 23, 31]. Spiritual resilience—arising from internal peace and a constructive outlook on mortality—explains why particular clinicians are drawn to palliative medicine [26]. Because of this, educational curricula must embed reflective methods that permit personnel to examine spiritual components within their own professional experiences.

Ultimately, closing the divide between research and practical application requires coordinated initiatives from healthcare institutions and policymakers. By institutionalizing mandatory, interdisciplinary education and standardized clinical protocols shaped by these behavioral and systemic factors, spiritual care can be shifted from a peripheral service into a sustainable, central element of holistic end-of-life treatment.

This systematic review provides a structured consolidation of spiritual care practice; however, its conclusions must be evaluated in light of several limitations. First, although the TDF provided analytical rigor, the fluid conceptual boundaries between domains (such as Optimism vs. Beliefs about Consequences) occasionally complicated the coding process's granularity. Furthermore, the TDF is inherently centered on individual behavioral drivers, which may minimize the apparent impact of macro-systemic factors such as institutional financing or the broader socio-cultural shift toward secularization. Second, the variable definition of "spiritual care" across the published literature poses a significant challenge. Because the phrase can encompass anything from religious rituals to secular existential concerns, it likely introduced inconsistency into how study participants responded. Finally, relying on qualitative self-reported data introduces vulnerabilities related to social desirability

and recall biases. In the absence of objective data tracking actual clinical practice, the facilitators and impediments identified in this analysis reflect stakeholders' perceptions rather than measurable clinical outcomes.

Conclusion

The integration of spiritual care within end-of-life environments encounters diverse obstacles that go beyond straightforward logistical constraints or knowledge gaps. This review illustrates that successful execution is fundamentally determined by behavioral drivers, most notably the rigid definition of professional roles and the conceptual ambiguity surrounding spirituality. Consequently, healthcare providers must serve as behavioral triggers; by proactively opening discussions, they can bridge the gap between patients' latent needs and their perceived role limitations. Without this deliberate engagement, palliative support cannot be deemed genuinely holistic.

To apply these insights in practice, administrators and policymakers must encourage a fundamental shift—moving away from "end-of-life spiritual rescue" toward longitudinal spiritual integration. First, all palliative care personnel must be provided with high-quality education that emphasizes communication proficiency and personal self-reflection, empowering them to manage their own preconceptions and anxieties. Second, spiritual care must be integrated directly into EMR systems and clinical protocols to ensure it is resourced and respected alongside physical treatments. Lastly, care delivery frameworks must be redesigned to facilitate the prolonged patient-clinician interactions required for existential openness.

Despite these constraints, this review serves as a vital introductory step toward comprehending the implementation environment through a dependable theoretical framework (TDF). By pinpointing these distinct behavioral and systemic limitations, we establish a framework for subsequent research, which must adopt greater methodological rigor and employ standardized measures to evaluate the influence of spiritual care on practical clinical endpoints.

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