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Cross-Sectional Study

Patients' Preferences for Addressing Spirituality During Hospitalization: A Cross-Sectional Study from a Lebanese Tertiary Care Center

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Abstract

In Middle Eastern societies, spirituality and religiosity play a central role in people's lives, regardless of faith tradition. This study investigates whether adult inpatients with cancer or critical illnesses wish to discuss their spiritual background during hospitalization, how their spiritual and religious convictions influence their medical decisions, and whether these beliefs provide emotional support in coping with disease. A structured questionnaire covering demographic details and spirituality-related questions was created and distributed to 100 patients as part of a cross-sectional study. The instrument underwent psychometric testing to establish reliability and validity, including a Principal Component Analysis (PCA) with Promax rotation to identify underlying dimensions. Further statistical analyses examined relationships between patient demographics and their spiritual preferences. Findings confirmed that the questionnaire is both reliable and valid for evaluating spiritual needs among this population. Nearly half of the respondents (45%) expressed interest in being asked about their spirituality, yet only a small fraction (4%) had actually discussed it with their medical team. Both Christian and Muslim participants demonstrated comparable interest in spiritual assessment. Compared with Lebanese participants, non-Lebanese patients were 4.8 times more likely to wish their spirituality to be acknowledged and twice as likely to believe it supported them in managing their illness ($p < 0.05$). Those in critical care units and patients with fewer hospital admissions in the previous year also showed a significantly higher interest in spiritual discussion ($p < 0.05$). Healthcare providers require formal training to better incorporate spirituality into patient-centered care, taking cultural context into account. Within this framework, caring for chronically ill patients should include acknowledging and addressing their spiritual concerns throughout their treatment journey.

Keywords: Spirituality, Cancer, Critical care, Holistic care, Lebanon, Psychometrics

Introduction

Spirituality refers to the dimension of human experience that involves the mind, emotions, and character, reflecting an individual's search for meaning and purpose in life events and experiences [1]. It may or may not be connected to organized religion or religious practice [2]. For many individuals, particularly in Middle Eastern societies, spirituality and religiosity (S/R) play a central role in shaping values, guiding life choices, and influencing health-related decisions [3, 4].

Spiritual care — understood as recognizing and addressing the needs of the human spirit in times of distress, illness, or grief — has become an essential element of holistic, patient-centered care. Its importance extends beyond end-of-life situations and is particularly emphasized in critical care contexts. Prior studies have demonstrated that many patients wish to discuss spiritual concerns with their healthcare providers [5], and this desire appears to be independent of the patient's level of spirituality [6]. Furthermore, the integration of spiritual

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care has been linked to improved patient-physician relationships, better emotional wellbeing, and enhanced clinical outcomes [7].

Despite these benefits, spirituality often remains overlooked in clinical practice, and discussions about it are rarely documented [3, 4]. Reported barriers include limited time, inadequate training or experience, discomfort with the topic, the perceived sensitivity of spiritual matters in intensive care environments, and uncertainty about how spirituality differs from religiosity [4, 5, 7–9]. Some healthcare professionals also view spirituality as a private matter that should not be addressed in the clinical setting.

Recognizing these challenges, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recommends that healthcare professionals receive formal training in spiritual assessment and integrate it into routine patient evaluation [10]. Similarly, the American College of Critical Care Medicine advises incorporating patients' spiritual needs into ICU care plans, promoting interdisciplinary assessments, and honoring patient requests for shared prayer or spiritual support [4].

In recent years, efforts have been made to conceptualize spirituality in healthcare and adapt its provision to specific populations. Cultural factors significantly shape how individuals perceive spirituality and its relevance to health and wellbeing. These perceptions vary across societies, age groups, and religious backgrounds [5, 11].

Although the role of spiritual care in medicine has gained attention worldwide and within the Middle East, limited research has explored the spiritual needs of patients in Lebanon. The Lebanese context is unique, characterized by rich religious and cultural diversity, with Christians, Muslims, Druze, and other faith groups living together within a small geographic area. While some studies have examined spirituality and religiosity in Lebanese healthcare settings [11–13], most have focused on spirituality in mental health or its role during the COVID-19 pandemic. Importantly, no validated tools currently exist to assess patients' spiritual needs in Lebanese hospitals.

In Lebanon's semi-conservative and multi-faith society, religion and spirituality are deeply intertwined, influencing patients' perspectives on illness and care. These factors shape both the willingness of patients to discuss spirituality with healthcare providers and the way spirituality informs their coping mechanisms. Given these cultural nuances, existing tools developed elsewhere may not fully capture local experiences. There is therefore a pressing need for culturally relevant instruments that reflect the Lebanese context.

This study seeks to fill this gap by developing and validating a culturally appropriate scale for assessing spiritual needs among Lebanese patients, and by exploring how critically ill and cancer patients at a tertiary care hospital experience and express spirituality during hospitalization.

The study objectives were:

1. To develop and evaluate the psychometric properties (factor structure and internal consistency) of a spirituality assessment tool for Lebanese patients.
2. To identify the spiritual care needs — including religious and existential dimensions — of hospitalized Lebanese patients, and to assess whether critically ill and cancer patients at the American University of Beirut Medical Center (AUBMC) wish to be asked about their spirituality by healthcare practitioners.

Materials and Methods

Aim

Considering the importance of culturally valid instruments in understanding spiritual needs, this study aimed to determine whether critically ill and cancer patients at the American University of Beirut Medical Center (AUBMC) wish to have their spirituality addressed and incorporated into their medical care. Additionally, it explored how patients' spiritual beliefs influence their medical decision-making and their ability to cope with illness.

Design

This study followed a cross-sectional design and included 100 adult patients diagnosed with critical illness or cancer. Participants were recruited from the American University of Beirut Medical Center (AUBMC) between February and April 2017. Eligible patients were those admitted during this period to the Adult Medical/Surgical ICU, Cardiac ICU, Respiratory ICU, and the Adult Oncology Center.

Inclusion criteria

Participants included men and women aged 18 years or older, of any nationality, who were medically competent according to their attending physicians. A medical student approached eligible patients and invited them to participate. Using the capacity form, it was ensured that each patient fully understood the study and provided informed consent. Of the 107 patients approached, seven declined participation.

Exclusion criteria

Patients who were intubated, comatose, or unable to make independent medical decisions were excluded, as were

pediatric and adolescent patients under the age of 18.

Questionnaire

A self-administered questionnaire was used for data collection, requiring approximately 10–15 minutes to complete. It consisted of two sections. The first included sociodemographic questions on age, gender, religion, marital status, educational level, employment status, monthly household income, and insurance coverage. The second section focused on spirituality and religiosity, exploring how patients' beliefs affected their coping with illness, health-related decision-making, and the physician-patient relationship.

Participants were also asked whether they had ever discussed their spiritual or religious beliefs with medical staff and if they would like their spiritual history to be taken by a member of the healthcare team. The questionnaire items were based on previous studies with similar objectives, including those by Ehman *et al*. (1999) on the influence of religious beliefs on illness decisions and outcomes [14], Palmer *et al*. (2021) on the patient-physician relationship [15], and Balboni *et al*. (2011) on patient-physician prayer in terminal cancer [16].

The final items were developed to focus specifically on spirituality and patients' need for spiritual care while avoiding overlap with mental health constructs [17]. Responses were recorded using a four-point Likert scale (Strongly Agree, Agree, Disagree, Strongly Disagree). The questionnaire was translated into Arabic, then back-translated by professional translators to ensure consistency with the original version.

A pilot test with 10 Lebanese patients was conducted to assess clarity and comprehension, and no modifications were required. Face and content validity were evaluated by expert reviewers. Construct validity was examined using principal component analysis (PCA) with Promax rotation to identify underlying components related to religious and spiritual needs.

The questionnaire was developed based on local qualitative findings rather than existing standardized scales, allowing the inclusion of culturally specific items. PCA was chosen to reduce data dimensionality and to generate component scores for further analysis. Since the components "inclusion of spiritual beliefs" and "importance of spirituality" were expected to correlate, Promax rotation with Kaiser normalization was applied. This oblique rotation was considered more suitable than Varimax, which assumes uncorrelated components.

- Maximum variability ($p = 0.6$) based on rougfl approximation from tfle literature review.
- A confidence interval of 95% (z).
- A precision level of 0.05 (d).
- A non-response rate of 20%.

According to the following calculations:

$$n= (z)^2*p*q/(d)^2 = (1.95)^2*0.6*0.4/(0.05^2) = 365. \quad (1)$$

The sample size was 100 participants due to time constraints and project timeline.

The internal consistency reliability of the questionnaire was checked using Cronbach Alpha which was calculated for the Likert scale variables and the dichotomized variables separately.

Data collection

Following approval from the Institutional Review Board (IRB) and the directors of participating hospital units, data collection commenced. Eligible and competent patients were approached with the assistance of their attending physicians, who introduced the study team. Each participant received a questionnaire along with an information sheet outlining the study's purpose and confirming the voluntary nature of participation.

As approved by the IRB, consent was obtained orally and did not require written signatures. Some participants chose to complete the questionnaire independently, while others preferred that the questions be read aloud and their answers recorded. Patients were offered the option to complete the questionnaire in either English or Arabic, depending on preference. All completed surveys were collected immediately after completion.

Statistical analysis

Data were analyzed using SPSS version 23 (IBM Corp., 2014). Descriptive statistics, including frequencies and percentages, were computed for all study variables, and frequency tables were used to summarize demographic data.

Three main outcome variables were defined:

1. Whether patients wanted their spiritual history to be taken by the medical team.
2. Whether patients' spiritual beliefs influenced their medical decision-making.
3. Whether patients' spiritual beliefs helped them cope with their illness.

Responses on the Likert scale were dichotomized: "Strongly Agree" and "Agree" were combined as "Agree," while "Disagree" and "Strongly Disagree" were combined as "Disagree."
Independent variables included demographic and socioeconomic characteristics such as age, sex, religion, marital status, number of children, nationality, place of residence, educational level, employment, income sufficiency, and health insurance coverage. Clinical variables included reason for admission (cancer or critical illness) and number of hospital visits in the past year (first visit, 2–9 visits, or 10+ visits).
Associations between categorical variables and the outcomes were assessed using the Chi-square test. Percentages of agreement and disagreement for each subgroup were reported. Binary logistic regression analyses were conducted to examine relationships between non-binary predictors and the dichotomous outcomes. Odds ratios (ORs), 95% confidence intervals (CIs), and p-values were calculated. Multivariate logistic regression models were used to control for potential confounders across the three outcome measures.

Ethical considerations
The study protocol received approval from the Institutional Review Board of the American University of Beirut Medical Center. Directors of the participating hospital units granted permission before patients were approached for recruitment.

Respect for individual autonomy
Participation in the study was entirely voluntary. Patients were informed that they could decline to answer specific questions or withdraw from the study at any time without penalty. The consent form provided sufficient explanation of the study's purpose and procedures, ensuring participants' autonomy and freedom from coercion.

Justice
All patients meeting the inclusion criteria were eligible for participation. Selection was conducted without any discrimination based on gender, religion, socioeconomic status, ethnicity, political affiliation, or cultural background.

Confidentiality
To maintain privacy, no names or personal identifiers were collected. This ensured the confidentiality of all participants and their responses.

Results and Discussion

Of the 107 eligible patients approached, seven declined to participate, yielding a total of 100 completed questionnaires and a response rate of 93.4%. The sample was predominantly male (62%) and married (83%), with most participants holding an educational degree (84%). About half (51%) were employed, and 62% reported sufficient socioeconomic means to cover their medical costs. Detailed sample characteristics are presented in **Tables 1a and 1b**.

Table 1. (a) sociodemographic characteristics of the sample population (N = 100). (b) spiritual beliefs of the sample population (N = 100)

Category	Characteristic	Percentage
a. Sociodemographic Profile of the Sample Population (N = 100)		
Age	Under 65 years	55%
	65 years and older	45%
Gender	Male	62%
	Female	38%
Marital Status	Never married	17%
	Married	83%
Education	Holds a degree	84%
	No degree	16%
Socioeconomic Status	Insufficient income for expenses	38%
	Sufficient income for expenses	62%
Employment	Currently employed	51%

	Not employed	49%
Religion	Muslim	72%
	Christian	19%
	Druze	4%
	Not specified	5%
Insurance	Has private insurance	57%
	No private insurance	43%
Nationality	Lebanese	84%
	Non-Lebanese	16%
Governorates	Resides in Beirut	53%
	Resides outside Beirut	47%
Hospital Visits This Year	First-time visit	24%
	1–9 visits	45%
	10 or more visits	31%
b. Spiritual Beliefs of the Sample Population (N = 100)		
Do you engage in prayer?	Yes	80%
Do you want your spiritual history recorded?	Yes	44%
Have you discussed spiritual beliefs with your doctor or healthcare provider?	Yes	4%
Do you believe there is a distinction between religion and spirituality?	Yes	62%

Reliability

The internal consistency of the questionnaire was evaluated using Cronbach's alpha. The Likert scale items demonstrated a strong reliability coefficient of 0.830, indicating good internal consistency. When the same variables were dichotomized, the Cronbach's alpha slightly decreased to 0.790, which still reflects an acceptable level of reliability.

Validity

To assess construct validity, a principal component analysis (PCA) was conducted. The analysis revealed a clear two-component structure, supporting the presence of underlying dimensions within the questionnaire. The PCA results were suitable for Promax rotation with Kaiser normalization, and the component correlation matrix **(Table 2)** confirmed the existence of correlations between the two extracted components.

Together, these two components explained 60.29% of the total variance, and all items loaded with factor values greater than 0.40, indicating strong associations with their respective components. Following Promax rotation, Principal Component 1 comprised five items reflecting the inclusion of spiritual beliefs in medical care, while Principal Component 2 included three items capturing the importance of spirituality to the patient. The structure and pattern matrices were consistent, displaying the same item groupings for each component **(Table 2)**.

Table 2. Correlation between the items and components of the spiritual needs questionnaire

Item	Component
	Significance of Spirituality
Do you want your spiritual beliefs integrated into your healthcare?	
You prefer your spiritual/religious beliefs to be taken into account in your healthcare treatment	0.879
Your spiritual/religious beliefs influence your health-related decision-making	0.738
You want medical staff to consider your spiritual/religious beliefs when making medical decisions	0.908
You believe incorporating your spiritual/religious beliefs enhances the relationship with your doctor	0.811
It is important to you whether your doctor is a spiritual or religious individual	0.401
You identify as a person with spiritual/religious beliefs	0.760
You believe your spiritual/religious beliefs play a key role in coping with your illness	0.740

Your spiritual/religious beliefs have evolved since the onset of your illness	0.777

Extraction Method: Principal Component Analysis. Rotation Method: Promax with Kaiser Normalization
a. Rotation converged in 3 iterations

Post-hoc power analysis

A retrospective power calculation was carried out to evaluate whether the study's sample size was sufficient to detect meaningful effects. Based on a total of 100 participants, an alpha of 0.05, an effect size of 0.2, and one degree of freedom, the achieved statistical power was 0.62, indicating moderate power. To reach the conventional 80% power threshold under the same parameters, a sample of roughly 157 participants would have been required.

Bivariate analysis

Preference for discussing spiritual history

Analysis revealed that non-Lebanese participants were considerably more inclined to want healthcare providers to inquire about their spiritual history compared to Lebanese participants (OR = 4.87, 95% CI: 1.45–16.4). Likewise, individuals admitted to critical care units were approximately four times more likely to express this preference than cancer patients (OR = 4.01, 95% CI: 1.74–9.30). Conversely, participants with frequent hospital visits (more than ten per year) were significantly less interested in being asked about their spirituality than those hospitalized for the first time (OR = 0.21, 95% CI: 0.07–0.65).

Influence of spirituality on medical decision-making

Residents of Beirut were nearly three times more likely to report that their spiritual beliefs influence their medical decisions compared to those living outside the capital (OR = 2.78, 95% CI: 1.23–6.31).

Role of spirituality in coping with illness

Compared to Lebanese patients, non-Lebanese respondents were more likely to view spirituality as an important coping resource (OR = 0.43, 95% CI: 0.09–2.04). Similarly, individuals without an academic degree showed a stronger tendency to rely on spirituality to manage illness (OR = 0.43, 95% CI: 0.09–2.04) **(Table 3)**.

Table 3. Correlation between the items and components of the spiritual needs questionnaire

Variable	Category	Patients Want Spiritual History Taken	Spirituality Impacts Medical Decisions	Spirituality Important in Coping with Illness
		Agree (%)	OR [95% CI]	Agree (%)
Age	Under 65 / 65 and Older	40.0 / 51.1	0.63 [0.26–1.51]	45.5 / 44.4
Nationality	Lebanese / Non-Lebanese	38.1 / 75.0	4.87* [1.45–16.4]	41.7 / 62.5
Governorate	Beirut / Outside Beirut	52.8 / 34.0	0.46 [0.21–1.03]	56.6 / 31.9
Educational Level	Holds Degree / No Degree	42.9 / 56.3	1.71 [0.58–5.04]	45.2 / 43.8
Socioeconomic Status	Insufficient Income / Sufficient Income	50.0 / 40.3	0.86 [0.38–1.93]	52.6 / 40.3
Reason for Admission	Cancer / Critical Care	30.4 / 63.6	4.01* [1.74–9.30]	44.6 / 45.5
Number of Hospital Visits in Past Year	First Visit	66.7	-	45.8
	1–9 Visits	44.4	0.40 [0.14–1.12]	48.9
	10 or More Visits	29.0	0.21 [0.07–0.65]	38.7

Note: Asterisks () indicate statistically significant odds ratios (OR) based on the provided confidence intervals (CI).
*Statistically significant association

Among the participating patients, 80% reported engaging in prayer. Of those who pray, 40% expressed a desire for their physicians to participate in prayer with them **(Figure 1)**.

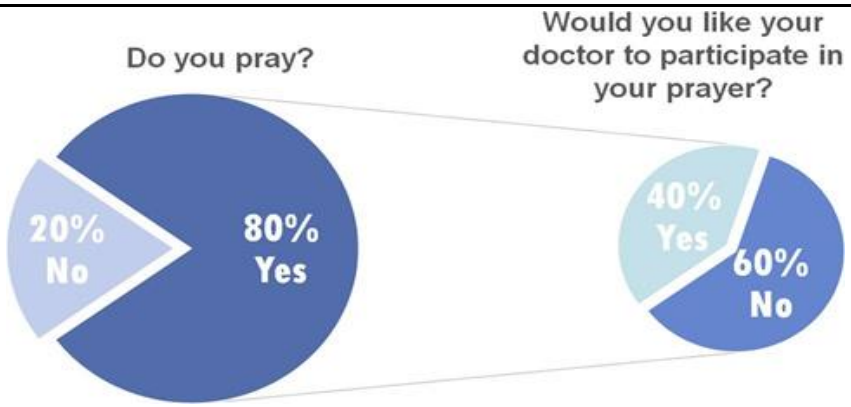

Figure 1. Patient prayer prevalence and the desire for physician participation in prayer based on the 80% of patients who reported praying

Among the 100 patients who participated in the study, five opted not to disclose their religious affiliation. Of the 95 who did, 72 (75.8%) identified as Muslim, 19 (20%) as Christian, and 4 (4.2%) as Druze. No statistically significant differences were found between these groups in terms of how they perceived the influence of spirituality on their health.

When asked about their preferred healthcare provider to discuss their spiritual history **(Figure 2)**, a majority (56%) indicated that they did not wish to have their spiritual history taken. Among those who expressed a preference, 5% selected a nurse, 6% a doctor, 14% a social worker, and 19% reported no specific preference.

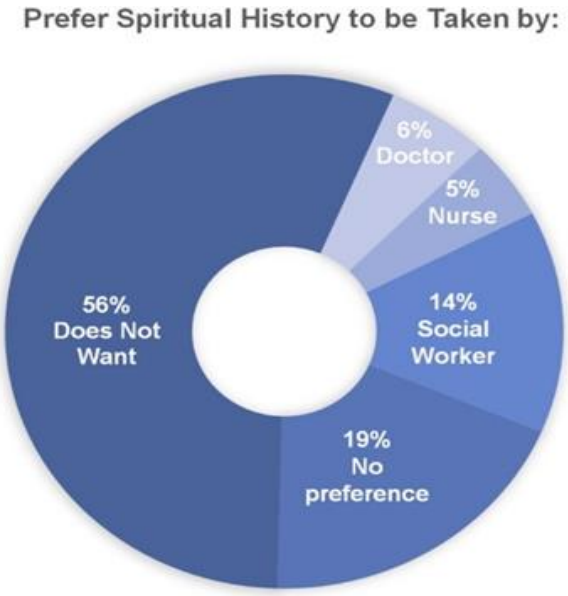

Figure 2. Patient Preferences for Healthcare Provider to Take Spiritual History

This study successfully validated a questionnaire designed to assess spiritual needs among Lebanese patients in critical care and oncology settings. Findings highlight a notable interest in spiritual care, varied understandings of spirituality, and the influence of cultural context. The results also revealed a strong association between higher questionnaire scores and patients' desire to discuss their spiritual history, indicating a substantial unmet need for spiritual engagement with healthcare providers.

Validation of the spiritual needs questionnaire

The validation process identified two main dimensions: the need to include spiritual beliefs in medical care and the personal importance of spirituality. This represents the first instrument in Lebanon specifically developed to assess spiritual needs in this patient population. Scores on the first component showed a strong correlation with the desire to have one's spiritual history taken (Spearman's rho = 0.86). Together, the eight items across the two components explained 60.29% of the total variance, with all items demonstrating strong factor loadings. While

the questionnaire may be adapted for use in other populations, it requires cultural and linguistic validation to ensure accuracy, as patient spiritual needs can vary considerably across settings.

Prevalence and significance of spiritual needs

Nearly half of the participants (45%) expressed a desire for healthcare staff to recognize and integrate their spiritual beliefs into medical decision-making, aligning with recommendations from the American College of Critical Care Medicine. This finding underscores the relevance of addressing spirituality in critically ill patients. Previous studies corroborate these results, demonstrating substantial patient interest in discussing spiritual matters [3–6, 11, 14]. A systematic review reported that a median of 70.5% of patients across various diagnoses considered it appropriate for physicians to inquire about spiritual needs, with interest increasing in severe illness [5]. ICU-based studies similarly indicate widespread recognition of spirituality's importance across diverse demographic groups [3]. Research in Lebanon also highlights the protective role of spirituality and religiosity in cancer and psychiatric patients, as well as strong spiritual self-perception in palliative care populations [11–13, 18, 19].

Spirituality versus religiosity

Among participants, 53% distinguished between spirituality and religiosity, 34% considered them equivalent, and 15% were unsure, emphasizing the need for clear definitions when addressing spiritual care. Patients with religious beliefs are often more receptive to physician-initiated discussions about spirituality during serious illness [14]. In ICU settings, studies such as Piderman *et al*. (2010) found that 77% of patients welcomed chaplain visits for divine connection and interpersonal support [20]. Lebanese cultural perspectives emphasize a dual relationship with God and others [13].

Although spiritual needs are consistently reported, interpretations vary widely. Spirituality is often linked to health through mechanisms such as meaning-making, peace, and interpersonal connectedness [16, 21–27]. Among cancer patients, spiritual engagement can enhance resilience and coping [11, 28]. Emotional regulation, prayer, and compassionate support are commonly cited means of receiving spiritual care [26–30]. In some studies, spirituality is closely tied to religious practices, particularly in predominantly Muslim regions where it is understood as a "return to God" and reliance on divine guidance [26, 29, 31–35].

Cultural variations in spirituality and religiosity

The study found that non-Lebanese patients placed greater importance on religion and spirituality for coping with illness and were more likely to wish for these topics to be addressed by healthcare providers compared to Lebanese patients. Many non-Lebanese participants were from the Arabian Gulf, where higher levels of religiosity and concepts such as *tawakkol* may explain this preference [10]. Cultural differences in spirituality are evident worldwide: for example, Iranian patients emphasize religion-based, moral, and humanitarian aspects of care, while Chinese patients prioritize creating a supportive environment and sharing personal experiences rather than religious practices. Systematic reviews in Chinese populations describe spirituality as multidimensional and abstract, encompassing internal strength, suffering, and cultural values [36–38]. In Australia, spirituality is often interpreted as finding meaning and purpose in life, with brief spiritual assessments integrated into routine care [39]. These examples underline the need for culturally sensitive approaches in addressing spiritual needs.

A notable portion of patients in this study indicated a desire for physicians to pray with them. Prayer has particular significance in Middle Eastern and African contexts [40–42], and physician-initiated prayer can strengthen the patient-provider relationship, though its appropriateness varies by individual preference [5]. Research from Pakistan and Iran similarly shows that patients value prayer with clinicians [24, 33]. In this study, Muslim and Christian patients were equally likely to see spirituality as important for coping and decision-making, independent of demographic factors.

Barriers to providing spiritual care

Despite significant interest, only 4% of patients who wanted spiritual discussions had engaged in them with medical staff, highlighting a substantial unmet need. Barriers include the absence of standardized protocols, high patient loads, limited training, and concern over cultural boundaries—issues reported globally [7]. Studies indicate that spirituality can positively impact quality of life and reduce distress [43].

Physician reluctance may stem from confusion between spirituality and religiosity, societal skepticism regarding religion in medicine [8], and personal beliefs influencing care [44]. Healthcare providers acknowledge the importance of spiritual care but often feel constrained by time, lack of confidence, or discomfort in initiating these conversations [39, 43, 45]. Comfort in addressing spiritual needs is more influenced by individual clinician factors than by a mismatch in religious affiliation with the patient [46, 47]. Ambiguity around the definition of spirituality persists [5], and studies on end-of-life care highlight the importance of communication skills and recognition of spiritual needs [48]. Older Lebanese physicians, in particular, may not view spiritual care as within their professional role.

Interestingly, patients with frequent hospital visits were less likely to want discussions about spirituality, which may reflect reliance on personal coping strategies, strong family support networks, or the perception that staff will not address these needs. Supporting this, a retrospective study in Chicago found that chaplaincy services were more commonly utilized by religiously affiliated and acutely ill patients [49].

Recommendations for integrating spiritual care into holistic practice

Healthcare providers should actively incorporate spirituality into patient-centered care using culturally appropriate and evidence-based strategies [38, 39, 42, 48, 50]. Distinguishing spirituality from religiosity allows clinicians to address broader existential concerns, moving beyond mere inquiry about religious affiliation to exploring what brings patients comfort and meaning.

Training programs should equip medical and nursing staff with skills to initiate open-ended, non-assumptive conversations. Structured education should include frameworks such as FICA (Faith, Importance, Community, Address in care) and HOPE (Hope, Organized religion, Personal spirituality, Effects on care). Residency programs and continuing medical education can further reinforce these skills through case-based learning and interprofessional collaboration.

Organizational support is also essential. Integrating spiritual history-taking into electronic health records ensures that providers consistently recognize and respond to patients' spiritual needs. Simple measures, such as adding a section on spiritual preferences in patient charts, can help translate discussions into practice. Ethical considerations—including autonomy, confidentiality, cultural sensitivity, and professional boundaries—must guide spiritual care. Providers should facilitate patients' exploration of meaning rather than provide religious counseling, and clear roles for chaplains should be established to support patient care.

Limitations

Several limitations of this study should be acknowledged. First, the sample size was relatively small, with only 100 participants, which may have limited the ability to detect statistically significant differences between subgroups, such as religious affiliations or age categories. A larger sample would allow for more detailed analyses and a better understanding of spiritual needs across diverse patient groups. Additionally, the small sample size may have influenced the results of the principal component analysis (PCA); a larger cohort would have strengthened the support for the factor structure of the developed questionnaire and improved overall statistical power, reducing the likelihood of Type II errors.

Second, the sample was drawn from a single tertiary medical center, which limits the generalizability of the findings to all critically ill and cancer patients in Lebanon. The study population may not fully represent the broader Lebanese patient population.

Finally, the reliance on self-reported data introduces the potential for response bias. The sensitive nature of questions about religion and spirituality may have influenced some participants' answers. Nevertheless, only seven eligible patients declined participation, suggesting minimal nonresponse bias.

Conclusion

This study highlights a clear unmet need for integrating spirituality and religious considerations into the care of cancer and critically ill patients in Lebanon. The discrepancy between patients' expressed desires for spiritual discussions and the actual provision of spiritual care underscores the necessity for systemic change. Healthcare providers should routinely inquire whether patients wish to discuss spiritual concerns and incorporate these conversations into ongoing care planning.

The questionnaire developed in this study offers a practical tool for identifying spiritual and religious support needs among critically ill and cancer patients. Training programs for clinicians and nurses should focus on building confidence and competence in addressing spiritual matters. Hospitals and healthcare institutions should establish clear policies and guidelines to ensure spiritual care is provided ethically and in alignment with patient values, including documenting spiritual history in medical records.

Future research should aim for larger, more representative, and multi-center samples. Incorporating qualitative methods can provide richer insights into patients' lived experiences and the nuanced role of spirituality in the Lebanese context. Investigating perspectives from healthcare providers and family members would further inform the feasibility and implementation of spiritual care interventions and clarify the impact of spirituality on patient and family well-being.

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Ethics statement: This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of the American University of Beirut: Institutional Review Board (Date 2018). Oral Informed consent was obtained from all individual participants included in the study. Both written and oral consents were taken from patients who were able to write.

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