A Scoping Review of Spiritual Care: Insights from Christian Family in Palliative Settings

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ABSTRACT

When it comes to palliative care, spirituality plays a crucial role in determining patients' quality of life and well-being by combining specific religious practices and personal beliefs. Through the utilization of a comprehensive search across ProQuest, ScienceDirect, and PubMed for qualitative studies published between the years 2019 and 2023, this scoping review investigates the role that Christian family caregivers play in providing spiritual care for their patients. The most important topics that emerged brought to light the various ways that spiritual care can be understood, the significant part it plays in patients' overall health and happiness, and the difficulties caregivers have while attempting to provide it. The results of the study indicate that there is a significant requirement for increased support and training for caregivers, which brings to light the difficulty of spiritual care in palliative care settings. The vital role of family caregivers in addressing spiritual needs to improve patient and family well-being is highlighted by the study, which emphasizes the need to incorporate spiritual care within palliative care practices and emphasizes the value of integrating spiritual care. In addition, it emphasizes the significance of transcultural care, particularly for Muslim nurses, who play an essential role in the healthcare field. It is possible for them to better serve patients of all races and religions if they adopt these concepts, which will ensure that care is respectful of patients' varied spiritual views. The provision of compassionate and holistic care is improved by the use of this technique, which also helps to bridge cultural gaps and enrich the palliative care experience for all parties concerned.

Keywords: Christian family caregivers, end-of-life care, palliative care, qualitative research, spiritual care.

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INTRODUCTION

Spirituality, derived from the Latin word spiritus, meaning "spirit or breathing" (Merriam-Webster, n.d.), can be described in various ways. Several dictionary definitions have been explored to elucidate the meaning of spirituality. According to the Cambridge Dictionary (n.d.), 'spirit' refers to "the way a person is feeling." In contrast, spirituality is defined as "the quality that involves deep feelings and beliefs of a religious nature, rather than the physical parts of life." Meanwhile, the Oxford Advanced Learner's Dictionary (n.d.) defines 'spirit' as "the part of a person that includes their mind, feelings, and character rather than their body," while spirituality means "the quality of being connected with religion or the human spirit." Thus, both dictionaries suggest that spirit is related to individual feelings, whereas spirituality pertains to religion and individual beliefs.

Several scientific publications have also been examined to define spirituality. "Spirituality and religiosity are often used interchangeably, but they possess distinct characteristics," Clyne et al. (2022) noted. They describe spirituality as a broad notion that may or may not incorporate religion. Alrukban et al. (2023) also noted that "spirituality and religiosity possess distinct characteristics." Puchalski et al. (2014), on the other hand, defined spirituality as a "dynamic and intrinsic aspect of humanity through which individuals seek ultimate meaning, purpose, and transcendence, and experience relationships to self, family, others, community, society, nature, and the significant or sacred," they differentiated it from religiosity, which refers to individuals' faith-based belief

systems (Kurubaran et al., 2020). Spirituality is distinguishable from religiosity because it is a dynamic and intrinsic aspect of humanity.

In the Muslim faith, the concept of spirituality holds a central place and is deeply intertwined with its religious principles, forming the bedrock of a spiritually guided way of life. Conversely, for non-Muslims, spirituality is not always equated with religious practices or beliefs (Herlianita et al., 2018). Maiko et al. (2019) distinguish between individuals who identify as "spiritually religious," encompassing both religious and spiritual dimensions, and those who see themselves as "spiritual but not religious," highlighting a nuanced understanding of spirituality. In Western philosophy, spirituality is interpreted in varied ways: Christians view it as a relationship with God, while proponents of New Age or mystical philosophies describe it as humanity's response to the world and their environment (Fitch & Bartlett, 2019).

According to the World Health Organization (WHO, 2020), palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual. Thus, in palliative care, spirituality is widely regarded as a vital element that significantly shapes the end-of-life experience for both patients and their family caregivers. Research indicates that higher levels of spirituality and religiosity are associated with slower disease progression, more effective coping mechanisms, and expedited healing processes (Kurubaran et al., 2020). Furthermore, active involvement in religious practices has been linked to better mental and physical health outcomes, which, in turn, contribute to higher survival rates among individuals facing life-threatening illnesses (Kurubaran et al., 2020). Adding to this perspective, Clyne et al. (2022) underscored the improved quality of life observed in patients who received spiritual support from family members. This underscores the pivotal role of family caregivers in addressing the spiritual needs of individuals receiving palliative care.

This study adopts a scoping review approach, which is particularly suitable for mapping key concepts and identifying gaps in research related to spiritual care provided by Christian family caregivers in palliative settings. Given the exploratory nature of the topic and the diversity of qualitative studies available, a scoping review is appropriate to comprehensively synthesize the literature without the constraints of assessing the quality or effect size as in systematic reviews (Munn et al., 2018). This approach allows for the inclusion of a broader range of study designs and methodologies, making it ideal for topics that are complex and heterogeneous.

Aim of Scoping Review

Providing an overview of the research that has been previously published on the topic of spiritual care in palliative care among Christian family caregivers is the major objective of this scoping review. In addition, it strives to get an understanding of the roles that family Christian caregivers play in the provision of spiritual care to their family members who are receiving palliative care and to investigate the difficulties that they have when attempting to fulfill these duties. In addition, the purpose of this evaluation is to identify any gaps that may already exist in the research and to suggest potential solutions to fill these gaps.

METHOD

This scoping review was conducted using the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) guidelines, which provide a 22-item checklist developed to ensure the rigorous and transparent reporting of scoping reviews (Tricco et al., 2018). The guidelines ensure a systematic approach to the identification, screening, and inclusion of relevant studies. The PRISMA-ScR framework was chosen due to the review's objective of mapping key concepts, exploring caregiver roles and challenges, and identifying research gaps rather than evaluating intervention effectiveness or synthesizing outcomes quantitatively. Unlike systematic reviews (SLRs), which focus on narrowly defined questions and often require homogenous study designs, scoping reviews are more flexible and inclusive of diverse evidence, making them particularly well-suited for this study's aim.

A comprehensive literature search was carried out on three electronic databases: ProQuest, ScienceDirect, and PubMed. The search strategy used specific keywords related to spiritual care in palliative settings, combined with Boolean operators.

A total of 1924 records were found through database searches. After removing duplicates, 1919 records were left. Two independent reviewers screened these records based on their titles and abstracts. Full-text articles were assessed for eligibility based on predefined inclusion and exclusion criteria. Any disagreements between the reviewers were resolved through discussion or consultation with a third reviewer. A PRISMA flow diagram in Figure 1 visually summarizes the study selection process, including reasons for exclusion at each stage. The reporting of this review followed the PRISMA checklist to ensure comprehensive coverage of all relevant aspects.

Search Engines

ProQuest, ScienceDirect, and PubMed were the three electronic databases that were utilized for this research project. The ability of these databases to provide a diverse selection of articles that are pertinent to the subject of interest was a primary factor in their selection.

Search Strategies

Keywords

The search technique utilized the Boolean operators "AND" and "OR" to increase the level of specificity of the search results. The keywords chosen were as follows: (spiritual care OR spiritual need) AND (palliative care OR end-of-life care OR terminal care) AND (Christian OR Orthodox OR Protestant OR Catholic) AND (family caregiver OR family OR caregiver) AND (perspective). Table 1 illustrates how these keywords were accomplished.

Table 1: Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) Framework

SPIDER		Keywords
S	Sample	Christian family caregivers OR orthodox family caregivers OR protestant family caregivers OR catholic family caregivers
PI	Phenomenon of Interest	Spiritual care in palliative care
D	Design	Interview, Questionnaire
E	Evaluation	Experiences
R	Research type	Qualitative study and Cross-sectional study

Inclusion and Exclusion Criteria

To direct the process of searching for and reviewing articles, the researcher has established particular inclusion and exclusion criteria. All of the criteria that will be utilized during the database search are outlined in the following paragraphs.

Inclusion Criteria

A significant part of the screening process for suitable papers will consist of analyzing the titles and abstracts of the articles to identify those that satisfy the inclusion criteria listed below:

- Articles concerning the spiritual side of palliative care and its implications.
- Articles written in English and published.
- Publications that were made available during the years 2019 and 2023.
- The accessibility of articles in their entirety.

Exclusion Criteria

The following are examples of criteria that are used to exclude articles from consideration:

- Articles that are systematic reviews.
- Articles that are not available to the public.

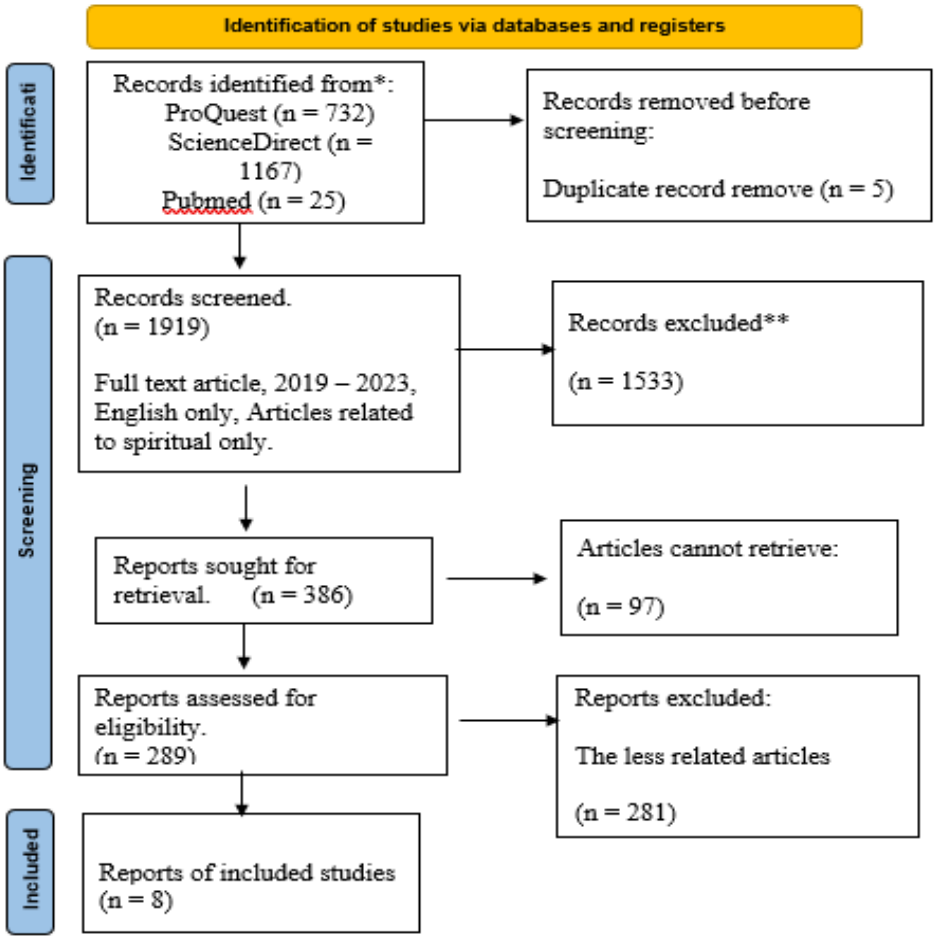

Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Table

CRITICAL APPRAISAL

Both qualitative and quantitative articles were evaluated using the Joanna Briggs Institute Critical Evaluation Tools as part of the critical evaluation process. These tools were used to determine whether or not the articles were relevant and legitimate.

RESULTS AND ANALYSIS

The results were analyzed using thematic synthesis, a collaborative process where the research team systematically coded the retrieved data to identify and construct key themes. In qualitative research, text elements are examined to uncover significant patterns and overarching themes (Bazeley, 2009). This iterative approach allowed for a comprehensive synthesis of the literature, with ongoing comparisons ensuring the refinement and accuracy of the identified themes. To evaluate the methodological quality of each study, the Joanna Briggs Institute (JBI) Critical Appraisal Tool was employed. This evaluation focused on critical aspects such as the clarity of the research question, the appropriateness of the study design, the rigor of data collection, and the validity of the conclusions drawn.

DISCUSSION

After reading through the papers that were chosen, three important themes were identified. They are: (1) Family Caregiver Perspective on Spiritual Care, (2) Family Caregiver Roles in Providing Spiritual Care to Their Family Members Receiving Palliative Care, and (3) Challenges in Delivering Spiritual Care. Each of the themes will be discussed in further depth in the subsequent subsections.

Theme 1: Family Caregiver Perspective on Spiritual Care

As stated by O'Callaghan et al. (2019), the majority of Christian family caregivers define spiritual care as the provision of assistance in the management of disease and its effects, the participation in conversations to create peace, the alleviation of dread of death, and the contemplation of the meaning of life. Some people believe that spiritual care encompasses both spiritual and religious problems, and they acknowledge the importance that organized religion, rituals, and faith traditions play in offering solace and support to people who are dealing with end-of-life challenges or illnesses. By focusing purely on spirituality, which encompasses personal views, values, inner peace, connectedness, and existential issues regarding the meaning and purpose of life, some people may define spiritual care more expansively**.** The expansive view goes beyond traditional religious practices and rituals, encompassing a wide range of beliefs and experiences that contribute to an individual's spirituality. In a healthcare setting, nurses may provide expansive spiritual care by:

- Offering a peaceful area for reflection or meditation.
- Facilitating group discussions on meaningful topics.
- Encouraging patients to share their stories and experiences as part of their healing journey.

A study by Wikert et al. (2022) explored how family caregivers of terminally ill cancer patients perceive and express spirituality in the context of spiritual care. The findings revealed diverse perspectives among participants. Some associated spiritual care with a sense of connection to people, places, and objects, while others linked it more directly to religious beliefs and faith. Despite these differing views, all participants unanimously recognized spiritual care as a vital component of end-of-life care, emphasizing its positive impact on patients. They highlighted that receiving spiritual care provided them with hope and the strength to continue their caregiving roles. These findings underscore the importance of integrating spiritual care into palliative care practices to support both patients and caregivers in navigating challenging circumstances.

According to the findings of Ejem et al. (2021), the researchers discovered that Protestant family caregivers connected spiritual care to the quality of life of their patients. They believed that infusing spirituality and religiosity into spiritual care could assist patients in coping with their illnesses and considerably improve the quality of life they experienced. With the belief that prayer can assist in the management of their physical and emotional loads, a significant number of patients who are coping with serious illnesses tend to increase the amount of time they spend praying.

McNamara et al. (2020) state that the majority of family caregivers are aware of the significance of providing spiritual care to patients nearing the end of their lives. They express gratitude when they are offered spiritual treatment and express openness to healthcare experts who undertake spiritual assessment. The vast majority of people, on the other hand, think that spiritual care ought to be centered on the family, by enabling family caregivers to take the initiative and communicate their worries and requirements. Taking this approach recognizes the vital role that family caregivers play in bringing support and comfort to patients who are nearing the end of their lives, and it emphasizes the significance of incorporating family caregivers in decisions and talks surrounding spiritual concerns.

Theme 2: Family Caregiver Roles in Providing Spiritual Care to Their Family Members Receiving Palliative Care

According to Nkuranyabahizi et al. (2021), family caregivers play a significant role in the provision of spiritual care to their loved ones who are coping with disease or who are getting close to the end of their lives. Their engagement includes providing consolation through a variety of techniques, such as offering prayers, which many caregivers find solace in and consider a strong tool to support their loved ones. The offerings of prayers are one example of their involvement.

Rego et al. (2020) conducted a study to explore the influence of spirituality on decision-making in palliative care. The study revealed that most participants, identifying as Catholics, associated their spirituality closely with their faith or connection to God. It was recommended that palliative care teams, including family caregivers and healthcare professionals, remain vigilant for signs of negative religious coping. Collaborating with spiritual care providers is essential to address these concerns effectively and provide holistic care for patients.

Similarly, Maiko et al. (2019) highlighted the significant role that relationships with God and the religious community play for some religious patients. This underscores the importance of family caregivers recognizing and assessing these relationships to better understand their impact on the patient’s quality of life. By doing so, caregivers can offer more effective spiritual support and help mitigate emotional distress arising from feelings of abandonment or spiritual struggles.

Theme 3: Challenges in Delivering Spiritual Care
The authors Benites et al. (2022) underline the fact that one of the difficulties that family caregivers experience when providing spiritual care to patients is the fact that they are experiencing emotional strain. It can be challenging for caregivers to keep their calm and strength when they are seeing the illness and potential death of a loved one. This might impair their capacity to provide appropriate spiritual care and support to their loved ones.

Another difficulty that has been identified by Ejem et al. (2021) is the absence of support from experts working in the healthcare industry. Many workers in the healthcare industry avoid having conversations about spirituality and religiosity with patients and family caregivers, which makes the challenges that caregivers face much more difficult. A general lack of understanding among healthcare workers regarding the need for spiritual care may be a contributing factor in the occurrence of this problem. Other potential causes include personnel shortages, time constraints, hard workloads, and excessive workloads.

Fitch and Bartlett (2019) highlight how the burden on family caregivers is exacerbated when patients are hesitant to recognize healthcare professionals as spiritual caregivers. Many patients feel that their spiritual needs are better addressed outside the hospital environment, preferring to discuss their spiritual concerns with members of their religious community. As a result, when family caregivers are unable to provide the necessary spiritual care, they often need to seek support from priests, chaplains, or other spiritual care providers. This additional responsibility can further increase the strain on caregivers, who may already be carrying significant emotional and practical burdens.

LIMITATIONS OF THE STUDY

There three limitations in this study are as follows:
1. Sample Size and Diversity:
The studies included in this review primarily focus on a limited number of participants. This may not represent the broader population's diverse experiences and perspectives regarding spiritual care in palliative settings. Additionally, the geographic concentration of the studies limits the generalizability of the findings to other cultural and religious contexts.

2. Variability in Definitions:
There is a lack of standardized definitions for key concepts such as "spiritual care" and "spirituality," which vary significantly across studies. This variability can lead to inconsistent interpretations and understanding of the results, making it challenging to draw definitive conclusions.

3. Methodological Differences:
The inclusion of both qualitative and cross-sectional studies introduces variability in research methodologies, potentially affecting the comparability of results. The different research designs and data collection methods can result in biases and affect the reliability and validity of the findings.

IMPLICATIONS OF THE STUDY

The findings from this study have the following implications for nursing practice:
1. Interdisciplinary Collaboration:
Effective spiritual care requires collaboration among healthcare providers, including chaplains, social workers, and psychologists. Nurses should actively participate in interdisciplinary teams to ensure that patients' spiritual needs are addressed comprehensively and cohesively.

2. Policy Development:
Healthcare institutions should develop and implement policies that recognize and support the provision of spiritual care in palliative settings. This includes creating guidelines for spiritual assessments, documentation, and the inclusion of spiritual care in care plans.

3. Research and Evidence-Based Practice:
Ongoing research is essential to build a robust evidence base for spiritual care practices. Nurses should be encouraged to engage in research activities and apply evidence-based practices to continually improve the quality of spiritual care provided to patients and families.

CONCLUSION

The purpose of this scoping review is to illuminate the profound yet intricate role of spirituality in palliative care, with a focus on how Christian family caregivers perceive and implement spiritual care. The review highlights the transformative impact of spiritual care on improving the quality of life for patients in palliative settings while addressing the emotional and practical challenges faced by caregivers. It underscores the need for increased recognition, support, and integration of spiritual care into palliative care frameworks. Additionally, the authors advocate for providing training and resources to empower caregivers and healthcare professionals in delivering holistic and compassionate care that respects the diverse beliefs and practices of patients and their families.

Acknowledging and supporting the spiritual and religious needs of patients is particularly emphasized in Islamic teachings, as it aligns with respecting their values and beliefs throughout the care process (Ismail et al., 2022). This perspective is especially valuable for Muslim nurses, who represent a significant proportion of the nursing workforce. It equips them to effectively integrate transcultural care principles when caring for patients of various races and religions. By fostering an inclusive and empathetic healthcare environment, this approach enhances the overall quality of palliative care provided to all patients, regardless of their spiritual beliefs.

AUTHOR CONTRIBUTION

MFMI was designated with supervision, conceptualization, methodology and investigation. NFNS took charge of writing, review and editing, while SZS was in charge of data curation, formal analysis and visualization.

DECLARATION OF STATEMENT

The lead author confirms the manuscript's integrity, stating that it provides an honest, accurate, and transparent account of the reported study. No crucial aspects of the study were omitted and any discrepancies from the planned (and, if applicable, registered) study have been appropriately explained.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest regarding the publication of this paper.

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APPENDIX 1: LITERATURE REVIEW MATRIX

Study/ Author/ Year	Study Design	Purpose of Study	Dependent and independent variables	Study Population	Research Finding	Limitation
1. Patients' and Caregivers' Contested Perspectives on Spiritual Care for Those Affected by Advanced Illnesses: A Qualitative Descriptive Study (O'Callaghan et al., 2019)	Qualitative study	To understand an Australian cohort of patients' and caregivers' perspectives about experiencing and optimizing spiritual care in the context of advanced illness.	Not related	30 patients (17 male; mean age 70 years) and 10 caregivers (six male; mean age 58.9 years) participated. 27 identified as Christian, and 10 had no religion.	Participants described multifaceted and contested beliefs about spirituality. Many queried the tangibility of spirituality, but all valued respectful staff who affirmed personhood, that is, each individual's worth, especially when care exceeded expectations. They also resonated with positive organizational and environmental tones that improved holistic well-being. Participants stressed the importance of the hospital's welcoming context and skilled care, which comforted and reassured	The questions used in the interview framework specifically focused on care experiences in one Australian health service and a specific definition of spiritual care was used, whereas definitions of spiritual care can vary internationally . Besides, views from people with same affiliations, including "no religion,' are also not always shared. Therefore, thematic findings were not saturated and caution is needed when considering them in relation to regional Australian and international contexts
2. "Give them the door but don't push them through it": Family Attitudes Toward Physician-Led Spiritual Care in Pediatric Palliative	Qualitative study	To understand perceptions of pediatric caregivers toward physician-led R/S care	Not related	Inclusion criteria: (1) Caregivers >18 years old whose children had been referred to palliative care within the previous 6 months. Exclusion criteria: (1) Non-	Three recurrent themes emerged regarding physician-led R/S care: (1) Most caregivers view providing R/S care as a positive sign of physician empathy, while a minority (3/20) prefer to keep R/S and medical care	The limitation was not discussed in this study.

Medicine (McNamara et al., 2020)				English speaking (2) Parents with child who was imminently dying, or appeared emotionally distressed at time of initial approach, as determined by their palliative care provider.	separate, (2) many caregivers prefer R/S care from a physician with whom they have a close relationship and/or share a faith background, and (3) physicians should open the door, but allow families to lead conversations about R/S care. Caregivers have mixed perceptions on physicians engaging in R/S care; most prefer that families set the direction of R/S care for themselves and their loved ones. Physicians should be trained to evaluate families' spiritual backgrounds and needs in ways that respectfully open the door to these conversations.	
3. Exploring Culturally Responsive Religious and Spirituality Health Care Communications among African Americans with Advanced Heart Failure, Their Family Caregivers, and Clinicians (Ejem et al., 2021)	Qualitative study	To explore African Americans with advanced heart failure and their family caregivers' (FCGs) preferences about R/S in patient-clinician communication	Not related	Inclusion criteria for the parent ENABLE CHF-PC study included the following: (1) New York Heart Association (NYHA) stage III–IV or ACC/AHA Stage C or D or equivalent HF, (2) 50 years of age or older, (3) English speaker (4) reliable telephone	Patients' and FCGs' have different perceptions related to inclusion of R/S in health care. Patients' perspectives were as follows: (1) R/S is not discussed in clinical encounters and (2) R/ S should be discussed only if patient initiated. FCGs' perspectives about ideal inclusion of R/S represented	This is a qualitative study of all Protestant AA HF patients and FCGs from a single academic medical center in the Deep South and may not represent views of persons from other regions, races, or religions. Furthermore, the subset of AA HF patients and

				access Exclusion criteria for the parent ENABLE CHF-PC study included the following: (1) heart transplantation or mechanical circulatory assist device, (2) active Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) Axis I diagnosis (e.g., schizophrenia or bipolar disorder), excluding major depression or generalized anxiety disorder (3) non-correctable hearing loss (4) dementia or cognitive impairment determined by the Callahan Cognitive Screen	three main diverging themes: (1) clinicians' R/S communication is not a priority, (2) clinicians should openly acknowledge patients' R/S beliefs, and (3) clinicians should engage in R/S conversations with patients.	FCGs interviewed was a result of voluntary participants already involved in a related clinical trial. For these reasons, the results of this study are not generalizable, but they may be transferable
4. "You begin to give more value in life, in minutes, in seconds": spiritual and existential experiences of family caregivers of patients with advanced cancer receiving end-of-life care in Brazil (Benites et	Qualitative study	To understand the spiritual and existential experience of family caregivers of patients with advanced cancer facing the end of life in Brazil.	Not related	16 family caregivers of hospitalized terminally ill cancer patients in Brazil. Inclusion criteria: (1) A spouse, relative, or friend who was providing care during the hospitalization of a patient with advanced cancer near the end of life;	s Three superordinate themes in their spiritual and existential experience were identified: (i) connectedness through caregiving, personal relationships, and spiritual beliefs; (ii) shifting hope: from death as a possibility to preparation for impending death; (iii)	Participants were primarily Christians, which may limit in the generalizabilit y of findings to other religious groups.

al., 2022)				(2) Awareness of the advanced cancer prognosis, with cure no longer the goal of care (3) Over 18 years of age	reframing suffering and meaning. For these caregivers, the relationship with the patient and with others, their spiritual beliefs, and hope were significant sources of meaning. Hope was sustained by death avoidance, oscillating with death acceptance and hope that it would occur with comfort. Family caregivers also experienced existential and spiritual suffering in the form of guilt, suppressed emotions, and loneliness	
5. Patient Perspectives about Spirituality and Spiritual Care. (Fitch & Bartlett, 2019)	Qualitative descriptive design	To explore the perspectives regarding spirituality and spiritual care held by individuals with advanced disease.	Not related	16 patients from outpatient palliative care clinics, inpatient acute care wards, and the palliative care unit at Sunnybrook Health Science Centre. Inclusion criteria: (1) Patients with advanced disease (2) Prognosis less than 12 months.	Four overall themes were identified: Spirituality is personal, spiritual distress is about separation, spiritual care is about connecting, and conversations about spirituality must align with the patient's beliefs. Subthemes emphasized the individuality of spiritual expression, the potential for illness impacting spiritual beliefs, and the value of connections to one's spiritual community. Participants thought	The limitation was not discussed in this study.

					healthcare providers needed to be able to identify individuals who were experiencing a spiritual struggle, acknowledge the reality of that struggle, and connect the individual with the appropriate resource or person.	
6. Spiritual Experience of Adults with Advanced Cancer in Outpatient Clinical Settings. (Maiko et al. 2019)	Simple qualitative study	To understand advanced cancer patients' spiritual and religious strength and distress.	Not related	21 patients receiving cancer care at the outpatient clinic of the Indiana University Health Simon Cancer Center. Inclusion criteria: (1) Patient with stage 4 solid malignancy with estimated survival less than 12 months (2) Receiving cancer care at the outpatient clinic of the Indiana University Health Simon Cancer Center (3) Age more than 18-year-old (4) More than 2 weeks from advanced cancer diagnosis (5) Have working phone number (6) Able to provide informed consent and able to obtain a score of 3 or higher on a	Using a thematic-analysis approach, five major themes emerged. Relationships with family and friends were the most important theme among all 21 patients irrespective of their religious or spiritual identity. Relationship with God and faith community was frequently identified by those who considered themselves spiritually religious. Cancer often led to reflection about the meaning of life and the nature of existential suffering. Patients addressed the extent to which identity was changed or maintained through the cancer experience, and some expressed acceptance as a way of coping with illness.	This study cannot be generalized since the population was mostly Christian, religious, white and economically stable. Then, only one investigator (research chaplain) is involved in qualitative interviews, which may result in systematic response bias that may limit the validity of findings. Finally, although the qualitative interviews are designed to be open-ended, all have structure that may create bias.

				six-item cognitive screener. Exclusion Criteria: (1) Have psychiatric or cognitive impairment (dementia/delirium, active psychosis that in the judgment of the physician or nurse would impede providing informed consent, involvement in other psychosocial research study at the cancer center (2) Inability to complete interviews in English.		
7. The influence of spirituality on decision making in palliative care outpatients: a cross-sectional study (Rego et al. 2020).	Cross-sectional study	To explore the influence of spirituality on the perception of healthcare decision-making in palliative care outpatients	Independent variable – spirituality Dependent variable – decision making	4 participants from outpatients' palliative care programs. Inclusion criteria: (1) Able to speak the native language (2) Have sufficient cognitive abilities to understand the questions. Exclusion criteria: (1) Subjects in a vulnerable state (2) Lacked the ability to understand the administered questionnaires (3) Could not provide informed	Spiritual wellbeing significantly correlated with greater levels of physical, emotional, and functional wellbeing and a better quality of life. Greater spiritual wellbeing was associated with less decisional conflict, decreased uncertainty, a feeling of being more informed and supported and greater satisfaction with one's decision. Most patients successfully implemented their decision and identified themselves as capable of early decision-	The limitation was not discussed in this study.

				consent.	making. Patients who were able to implement their decision presented lower decisional conflict and higher levels of spiritual wellbeing and quality of life. Within the 16 themes identified, spirituality was mostly described through family. Patients who had received spiritual care displayed better scores of spiritual wellbeing, quality of life and exhibited less decisional conflict. Patients considered spirituality during illness important and believed that the need to receive spiritual support and specialized care could enable decision-making when taking into consideration ones' values and beliefs	
8. Caring experiences and support needs among family caregivers of patients with End Stage Renal Disease (ESRD) in Rwanda: A descriptive qualitative study (Nkuranyabahizi et al., 2021)	Qualitative study	To explore the experiences of caring and support needs of the family caregivers of patients with ESRD at selected hemodialysis units in Rwanda.	Not related	12 participants Inclusion criteria: (1) Family caregivers of patients with confirmed ESRD that had been on hemodialysis for at least 6 weeks (2) Able to communicate in Kinyarwanda or English language	The emerging themes for caring experiences were: "personal issues", "spiritual issues" and "sense of satisfaction". The need for dialysis policy change, shelter and psychological counselling were highlighted by the family caregivers.	The researcher only included family caregivers of patients who were in the renal unit at the time of the study leading to information bias. Additionally, recall bias was quite possible as the participants were requested to recall and

				(3) Ages of 18 years or older. Exclusion criteria: (1) All family caregivers of patients with acute kidney injury (AKI) on hemodialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD) (3) Newly diagnosed ESRD patient (less than 6 weeks).		narrate caregiving experiences. Finally, the researcher bias emanating from preconceived ideas of ESRD might have occurred, leading to misinterpretation of information