Nurses’ and midwives’ acquisition of competency in spiritual care: A focus on education

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Background: The debate that spirituality is ‘caught’ in practice rather than ‘taught’ implies that spiritual awareness comes about through clinical experience and exposure, requiring no formal education and integration within the curricula. This is challenged as it seems that providing students with a ‘taught’ component equips students with tools to identify and strengthen resources in ‘catching’ the concept.

Aim: This study forms part of a modified Delphi study, which aims to identify the predictive effect of pre- and post-registration ‘taught’ study units in spiritual care competency of qualified nurses/midwives.

Methods: A purposive sample of 111 nurses and 101 midwives were eligible to participate in the study. Quantitative data were collected by the Spiritual Care Competency Scale (SCCS) (Van Leeuwen et al., 2008) [response rate: nurses (89%; n = 99) and midwives (74%; n = 75)].

Results: Overall nurses/midwives who had undertaken the study units on spiritual care scored higher in the competency of spiritual care. Although insignificant, nurses scored higher in the overall competency in spiritual care than the midwives.

Conclusion: ‘Taught’ study units on spiritual care at pre- or post-registration nursing/midwifery education may contribute towards the acquisition of competency in spiritual care.

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Introduction

Spiritual care is the provision of interventions that assess and address patients’ spiritual needs in collaboration with the multidisciplinary team (Hospice and Palliative Nurses’ Association (HPNA), 2007; Smith, 2006). Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires (NHS Education for Scotland, 2009 p. 6). Examples of interventions are as follows: respecting patients’ religious/faith and cultural beliefs; communicating sensitively by listening to and talking with clients; being with the patient by caring compassionately; supporting, showing empathy; facilitating participation in religious rituals; promoting a sense of well-being; and referring to chaplains and other professionals (Baldacchino, 2009; McClung et al., 2006; McSherry and Ross, 2002). Thus, spiritual care contributes towards holistic care (Puchalski and Romer, 2000) and positive outcomes in clients (Koenig et al., 2012; Meisenhelder and Chandler, 2002; Hall, 2007).

Factors that contribute towards competence in spiritual care are learning from role models in the clinical field (Bradshaw, 1997), personal spirituality (Bailey et al., 2009), life experiences (Deal, 2010), past hospitalisation experiences (Chan, 2009), working in obstetric wards (Hall, 2007), person-centred organisation of care (McCance et al., 2009) and students’ age and maturity (Wallace et al., 2008). Conversely, spiritual care is overlooked by health care professionals as it is considered as the chaplains’ role (Lovanio and Wallace, 2007). This is because spirituality is defined synonymously with religiosity (Biro, 2012) and feelings of incompetence due to lack of education (Baldacchino, 2008b, 2011).

The importance of integrating spiritual care within the nursing/midwifery curricula is to enhance competence in meeting clients’ needs holistically (Nursing, Midwifery Council (NMC), 2010). However, Paley (2007) argues that spiritual care should not be given by nurses at all as patients tend not to expect it from nurses (Ross, 2006). In contrast, patients perceive spiritual needs as part of the overall care given by the health care professionals and the pastoral teams (Baldacchino, 2003; Saliba and Baldacchino, 2010). Since nurses/midwives are constantly...
attending to clients’ needs, the need to integrate spiritual care in the respective curricula is essential (Abbas and Dein, 2011).

The spiritual dimension has been overlooked by health care professionals as the concept of spirituality is still poorly understood due to various reasons such as lack of education (Saliba and Baldacchino, 2010), ambiguity between the two complex concepts of spiritual care and psychological care (Bailey et al., 2009) and interpretation of spirituality synonymously with religiosity, rendering definition of spirituality to be ‘outdated and not in keeping with modernist, multicultural or indeed secular views of the term’ (McSherry, 2007, p. 25).

Research to date on the impact of teaching on spirituality in nursing is on the increase. However, only one study was traced on teaching spirituality to midwifery students (Hall, 2007). Measuring nurses’/midwives’ competences in spiritual care following education is still in its infancy (Van Leeuwen et al., 2008). Hence, this study aims to assess the level of competency in spiritual care of qualified nurses/midwives, after undertaking study units delivered by the second author at the University of Malta.

Aim

To identify the predictive effect of pre- and post-registration ‘taught’ spiritual care study units on the competency of qualified nurses/midwives.

Conceptual framework

The study was guided by an amalgamation of three educational theories which include the theory of novice to expert (Benner, 1984), Bloom’s taxonomy (1956) and the theory of reflective practitioner (Schön, 1991).

Benner’s theory is based on an adaptation of the five stage model of skill acquisition (Dreyfus and Dreyfus, 1980). The term skill incorporates the psychomotor skill performance and all aspects of practice including knowledge, behaviours, values and attitudes (Benner, 1984). Performance is classified into five different levels of proficiency: novice, advanced beginner, competent, proficient and expert. While students progress from one level to another, they move from analytic, rule-based thinking to intuition with an ability of addressing complexity in care. Eventually, students move from a detached observer to an actively involved caregiver (Benner and Wrubel, 1989). Thus, Benner’s (1984) competency-based approach may be used to achieve competency in spiritual care at both the pre- and post-registration levels of nursing/midwifery education. However, at the point of registration students are expected to reach proficiency level 3—competence which involves the nurses/midwives’ ability to demonstrate efficiency; coordinate their actions with confidence; establish a plan based on considerable conscious, abstract and analytic contemplation of the problem; and complete care within a suitable time frame. Higher levels of proficiency (levels 4 and 5) may be achieved after several years of clinical experience, which render this level to be appropriate to post-registration nursing/midwifery education.

Bloom’s taxonomy (1956) is consistent with Benner’s theory as it provides guidance in formulating the competencies’ educational objectives in spiritual care, arranged in hierarchical levels. A goal of Bloom’s taxonomy is to motivate educators to focus on all three domains, creating a more holistic form of education. The cognitive and affective domains are the most relevant when achieving competency in spiritual care. Skills in the cognitive domain are oriented towards knowledge, comprehension and critical thinking. The affective domain includes the skills in dealing with people emotionally such as feelings, values, appreciation, enthusiasm, motivation and attitudes.

The reflective practitioner (Schön, 1991) proposes reflection-in-action and reflection-on-action as an intrinsic part of the professional education. This infers an interaction between thinking, action and being. The knowledge gained from the study unit (knowing that/about) is applied critically to action (knowing-in-action). During the process of knowledge attainment, individuals may restructure their methods of action, contributing towards an outcome of competence in assessing, planning, implementing and evaluating spiritual care. The process of achieving competence in spiritual care is closely related to the student’s ability to focus on self-reflection to clarify own values, become self-aware, be able to engage in self-monitoring and self-regulation and learn from experience (Bandura, 1997). Hence, self-awareness through self-reflection is fundamental to instigate effective spiritual care (Narayanasamy, 1999; Cone and Giske, 2013).

Teaching on spiritual care

Since 2003, study units on spiritual care had been taught to undergraduate and post-graduate nursing/midwifery learners at the Faculty of Health Sciences, University of Malta (Baldacchino, 2008a,b, 2011). The aim is to define spirituality and spiritual care, increase self-awareness about personal spirituality and increase knowledge about the spiritual dimension of illness and care. This is then transferred to patient care, guided by reflection in-action and on-action in order to become competent in meeting patients’ needs holistically.

Education and competency in spiritual care

The spiritual dimension of holistic care has been considered by health care organisations as fundamental to health and well-being (World Health Organisation, 1998; European Convention on Human Rights, 2000; International Council of Nursing, ICN, 2006). Similarly, nursing/midwifery education is requested to integrate the spiritual dimension of care in both the theoretical and clinical components (NMC, 2010). On qualification nurses/midwives are expected to be competent in the systematic holistic assessment of clients incorporating ‘the relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors...’ (NMC, 2010, p. 18). Additionally, nurses/midwives are expected to ‘demonstrate an understanding of how culture, religion, spiritual beliefs ... can impact upon illness and disability’ (NMC, 2010, p. 108).

Education on spiritual care demonstrated positive outcomes on pre-registration nursing students (Ross, 2006; Van Leeuwen et al., 2008) and qualified nurses (Waser et al., 2005; Baldacchino, 2011). Students were found to have increased knowledge about the definition of spirituality (Wallace et al., 2008; Baldacchino, 2008b, 2011), increased ability to deliver spiritual care (Louis and Alpert, 2000), positive attitudes and spiritual experiences (Lovanio and Wallace, 2007), increased self-awareness about personal spirituality (Sandor et al., 2006) and increased sensitivity towards patient centred care (Waser et al., 2005).

In contrast, education programmes made learners aware of the complexity of the spiritual dimension in care whereby assessment of patients’ spiritual needs was found difficult (Milligan, 2004; Baldacchino, 2011). Gender differences were found whereby females scored higher in the perceived importance of personal spirituality and patient spiritual care (Sandor et al., 2006). No significant differences were found between nurses and other health care professional groups in the attitudes towards spiritual care across time (Waser et al., 2005). In contrast, differences were identified between nursing and medical professional groups whereby medical students scored lower in the perceived less dogmatic spirituality than the nursing students across time (Milligan, 2004).

Various methodologies were found appropriate in teaching spiritual care such as journaling, reflective exercises, sharing of experiences and self-directed learning (Greenstreet, 1999; Baldacchino, 2008a). For example, case studies approach expose learners to a model of care in the clinical practice whereby a trustful encounter with patients may help them identify their spiritual distress and needs (Hoffert et al., 2007). Clinical practice helps learners to acknowledge the complexity of reality and may help them develop assessment skills and facilitate strategies to
meet patients’ needs holistically (Baldacchino, 2006; Wehmer et al., 2010).

Thus, taught spiritual care appears to transform the knowledge into competence in spiritual care (Mitchell et al., 2006; Van Leeuwen et al., 2008). The outcome of spiritual care education is consistent with the competences proposed by research such as delivering spiritual care by the use of the nursing process, maintaining trustful nurse–patient relationship, referral to a hospital chaplain and/or respective members of the multidisciplinary team, safeguarding ethical issues, self-awareness about personal spirituality and maintaining quality assurance (Van Leeuwen and Cusveller, 2004; Biro, 2012).

Research methodology

This descriptive study forms part of a larger modified Delphi study, which recruited nursing/midwifery experts.

Sample

A purposive sampling technique was adopted whereby all the nurses/midwives who had undertaken the study unit on spiritual care at the Faculty of Health Sciences were invited to participate. Since not all nurses/midwives can become experts in their field (Benner, 1984), all the qualified nurses (n = 369) who undertook the study unit on spiritual care at the Faculty of Health Sciences were invited to participate of whom 111 nurses consented to participate. The response rate was 88% (n = 99). Since only few midwives (n = 31) undertook the study unit and the number of midwives in Malta is relatively small when compared to nurses, they were all invited (n = 128) of whom 101 midwives consented. The response rate was 74% (n = 75).

Data collection and analysis

This study was approved by the University of Malta Research Ethics Board. Copyright permission was granted to use the Spiritual Care Competency Scale (SCCS) (Van Leeuwen et al., 2008). The SCCS is a Likert-form questionnaire that consists of 27 items ranging from 1 = completely disagree to 5 = fully agree. The demographic data incorporated the profession of nurses/midwives, education on spiritual care and pre- or post-registration course. The questionnaire was mailed to the participants in March 2012 with a reminder after three weeks and returned to the first author in the stamped self-addressed envelope. Participants were asked not to write their names to maintain anonymity and confidentiality.

The overall score of SCCS scale ranges between (27 and 350). It consists of six factors, namely, ‘the attitude towards patient spirituality’ (Q1–4; max score of 20); communication (Q5–6; max score: 10); assessment and implementation of spiritual care (Q7–12; max score 30); referral (Q13–15; max score 15); personal support and patient counselling (Q16–21; max score 30); professionalisation; and improving the quality of spiritual care (Q22–27; max score 30).

The data underwent descriptive and inferential statistical analysis by the SPSS version no. 18. Missing data (n = 63) were received on the ‘pre- or post-registration course,’ which might have included also those who did not undertake the study unit and overlapping programmes of education (pre-reg: n = 77; post-reg: n = 21; other: n = 8). Thus, these data were discarded and only two variables were computed, that is, profession and education on spiritual care.

Parametric statistical tests were used since the Kolmogrov–Shmirnov tests yielded p-values greater than the 0.05 level of significance, indicating the score distributions were normal. The Student t-test was used to identify possible differences between two mean scores derived from the subgroups of nurses/midwives and education/no education. The major limitation of the Student t-test is that it investigates solely the relationship between a dependent variable such as competence in spiritual care and a categorical predictor like undertaking the study unit on spiritual care. However, the goal of this study was also to estimate collectively the quantitative effect of the two predictors, namely, type of profession (nursing/midwifery), undertaking or not the study unit, upon the competency in spiritual care as the dependent variable. Regression analysis was computed to assess the predictive effect of the two predictors (profession and education) on the overall competency in spiritual care derived from the SCCS questionnaire (Van Leeuwen et al., 2008).

Findings

The findings indicate that the nurses and those who undertook the study unit on spiritual care scored higher in the overall competency of spiritual care with less SD in the overall scores of the midwives (Table 1). Student t-test revealed no significant differences in the overall scores by profession (t = 0.779; p = 0.437) and education on spiritual care (t = 1.944; p = 0.054). However, although insignificant, those nurses/midwives undertaking the study unit scored the highest mean score (M = 106.33; SD = 13.170) (Tables 1 and 2).

Nurses scored higher in five dimensions of competency in spiritual care except in the dimension of attitude towards patient’s spirituality in which midwives scored higher (M = 18.24; SD = 1.711). However, no significant differences were found in all the six dimensions between nurses/midwives (Table 3).

Although differences between mean competency scores were not significant, those who undertook the study unit on average scored higher in all the six dimensions of the competency in spiritual care (Table 4). Moreover, the two-predictor regression model, which describes 0.8% of the total variance of the competency scores (Table 5), indicates that education is the stronger predictor of the two variables (p = 0.089).

Discussion

Although non-significant, the nurses scored higher in the overall competence in spiritual care (M = 105.73; SD = 14.053) than the midwives (M = 104.37; SD = 8.999). This infers that since all the nurses (n = 95; 100%) had undertaken the study unit against only a small percentage of midwives (n = 11; 16%), other factors might have contributed towards the similar mean scores of the midwives such as life experiences and clinical practice. Increased awareness and knowledge following education on spiritual care had been found in undergraduate (Baldacchino, 2008a,b) and post-graduate nurses (Baldacchino, 2011). This finding sheds light on the transfer of knowledge into competence in spiritual care. Since competence incorporates knowledge, skills and attitudes (Bloom, 1956; McClung et al., 2006), further research is suggested to assess holistic competence during delivery of nursing/midwifery care.

In Malta, 95% of the population is affiliated with the Roman Catholic religion (Gouder, 2011). Pregnancy and childbirth are very often spiritualised, fostering a positive attitude towards spirituality. Research shows that childbirth is a time to become closer to the higher power/God, perceived as providing blessings and influencing birth outcomes.

Table 1

<table>
<thead>
<tr>
<th>Group</th>
<th>No.</th>
<th>Mean (max = 135)</th>
<th>SD</th>
<th>t</th>
<th>p, two-tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole group</td>
<td>163</td>
<td>106.79</td>
<td>12.681</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>95</td>
<td>105.73</td>
<td>14.053</td>
<td></td>
<td>0.779</td>
</tr>
<tr>
<td>Midwives</td>
<td>68</td>
<td>104.37</td>
<td>8.999</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertook study unit on spiritual care</td>
<td>106</td>
<td>106.33</td>
<td>13.170</td>
<td>1.944</td>
<td>0.054</td>
</tr>
<tr>
<td>Did not undertake study unit on spiritual care</td>
<td>57</td>
<td>102.62</td>
<td>9.763</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thus, childbirth appears to actualise the meaning of religiosity and renders religious practices as a means of empowerment (Callister and Khalef, 2010). This spiritual attitude helps midwives to address and meet clients' spiritual needs and deliver holistic care (Jesse et al., 2007).

Various factors were associated with a positive attitude towards spiritual care. For example, personal spirituality was reported as the strongest predictor of perceived ability to provide spiritual care (Van Leeuwen et al., 2008). Similarly, students' frequency of attendance to religious services and spiritual experiences contributed towards a positive attitude to delivery of spiritual care (Taylor et al., 2008). Personal life experiences may yield a positive impact on their attitude to meet clients' spiritual needs because they tend to become aware of the importance of priorities in life, life values and meaning and purpose in life (Ross, 1997; Catanzaro and McMullen, 2001; Van Leeuwen and Cusveller, 2004). However, conflicting findings were found by Ross et al. (2013), whereby no significant differences were found in the perceived delivery of spiritual care by students' life experiences. This merits further trans-cultural longitudinal research to compare the impact of life experiences on care delivered by undergraduate and post-graduate nurses/midwives. Furthermore, clinical experience was found to be transformational to the caregiver (Watson, 1999; Dijoseph and Cavendish, 2005). Through reflection in and on practice (Schön, 1991) nurses/midwives may become aware that while giving care to clients, they may also be on the receiving end (Chapman and Howkins, 2003; Gustafsson and Fagerberg, 2004; Baldacchino, 2010). This may be because caregivers are led to reflect and question the meaning and purpose of suffering and the preciousness of health and life (Baldacchino and Formosa, 2010).

Health care professionals have now been considering a person not just as a ‘conglomeration of separate entities but an indivisible whole’ (McSherry and Draper, 1998 p. 688). Communication in midwifery care by attentive listening to the stories of the individual childbearing women is important in order to identify attentively their spiritual experience of childbirth (Callister, 2004; Hall and Taylor, 2004). Eventually, the gap between the client’s needs as perceived by the mother herself and the health care professionals is minimised (Eldridge, 2007). Through the affective domain, Benner et al. (1996) and Bloom (1956) emphasised the importance of knowing the clients and of being emotionally involved in the development of nursing intuition, emphasising nurse/midwife-client relationships. Spiritual care applies to both the believers and non-believers (Baldacchino and Draper, 2001; Burnard, 1988). Thus, in times of distress such as the loss of a beloved baby in a miscarriage, trauma, fear of death, terminal illness such as cancer, multiple sclerosis, nurses and health caregivers are in a position to address clients’ spiritual needs, which may or may not include religious beliefs, by therapeutic use of self, active presence and compassionate care to help clients find meaning and purpose in their suffering and life (Evangelista et al., 2003; Lee et al., 2006; Hospice and Palliative Nurses’ Association, HPNA, 2007).

While beginners’ emotions are characterised by anxiety, which impedes their practice, more advanced nurses/midwives can rely on a larger repertoire of emotional responses, which is used as informative and guiding cues in attending to clients’ spiritual needs. These cues not only amplify nurses’ perceptual awareness, but also shape their clinical know-how, ethical comportment and emotional involvement with patients and their families (Giske, 2012).

The midwifery clinical environment appears to enhance acquisition of the skills to deliver spiritual care. Although few midwives have undertaken the study unit, midwifery care and the midwifery clinical environment appear to be conducive to learning spiritual care (Giske, 2012). Also in Malta, obstetric wards are considered by the administration as acute wards and therefore staff-complement is usually full, making client allocation system feasible. Once qualified, midwives are assigned to work on a six-month rotation in the obstetric wards for a two year period. This rotation system appears to foster implementation of holistic care, including spirituality (Callister and Khalef, 2010).

In contrast, although all the nurses in this study had undertaken the study unit, their clinical environment might have inhibited consistency in their competence to deliver spiritual care. Examples of inhibitors are work overload, impaired staff-complement, concealed task-centred care in patient allocation system and lack of continuing professional development programmes (Baldacchino, 2011).

Secularisation, modernism and the medical model of care may influence nurses/midwives to focus primarily on the physical perspective of patient care (Ross, 2006; Puchalschi, 2008). Similarly, scientific and technological advances in medicine were reported to have shifted the attention of the nurses/midwives from the individual person to the sophisticated equipment assisting the clients (Khademian and Vizeshfar,

<table>
<thead>
<tr>
<th>Factor</th>
<th>Name of factor</th>
<th>Nurses (n = 95), midwives(n = 68)</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p, two-tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attitude towards patient's spirituality (Q1–4) (max score: 20)</td>
<td>Nurses</td>
<td>18.14</td>
<td>1.966</td>
<td>−0.332</td>
<td>0.740</td>
</tr>
<tr>
<td>2</td>
<td>Communication (Q5–6) (max score: 10)</td>
<td>Nurses</td>
<td>18.24</td>
<td>1.711</td>
<td>0.092</td>
<td>0.928</td>
</tr>
<tr>
<td>3</td>
<td>Assessment and implementation of care (Q7–12) (max score: 30)</td>
<td>Nurses</td>
<td>9.09</td>
<td>1.042</td>
<td>1.150</td>
<td>0.252</td>
</tr>
<tr>
<td>4</td>
<td>Referral (Q13–15) (max score: 15)</td>
<td>Nurses</td>
<td>22.86</td>
<td>4.018</td>
<td>0.343</td>
<td>0.732</td>
</tr>
<tr>
<td>5</td>
<td>Personal support and patient counselling (Q16–21) (max score: 30)</td>
<td>Nurses</td>
<td>12.26</td>
<td>1.996</td>
<td>0.556</td>
<td>0.579</td>
</tr>
<tr>
<td>6</td>
<td>Professionalisation and improving the quality of spiritual care (Q22–27) (max score: 30)</td>
<td>Nurses</td>
<td>20.15</td>
<td>5.080</td>
<td>−0.288</td>
<td>0.774</td>
</tr>
</tbody>
</table>

Table 3

Student t-test: nurses’ and midwives’ competency by the six dimensions of spiritual care derived from the SCCS questionnaire (Van Leeuwen et al., 2008).
Additionally, research indicates that nursing/midwifery professionals appear to attract nurses/midwives with personalities of average openness and high agreeableness (Deary et al., 2003; Baldacchino and Galea, 2012a,b). Thus, although nurses/midwives are expected to be change agents, average scores in openness tend to limit their initiative to implement spiritual care. The high scores of agreeableness render the nurses to get absorbed in the health care system (Deary et al., 2003), which tends to overlook both the spiritual needs and holistic care (Narayanasamy, 2001; Baldacchino, 2011).

Despite the mentioned inhibitors, nurses (M = 105.73; SD = 14.053) managed to score higher than the midwives (M = 104.37; SD = 8.999). Similarly, those who undertook the study unit (n = 106: nurses: n = 95; midwives: n = 11) scored higher in competency in spiritual care. Additionally, although not significant, regression analysis showed education as the stronger predictor (B = -3.909; p = 0.089) than the ‘profession’ (B = -0.435; p = 0.843). Thus, irrespective whether the participants were nurses or midwives, the contributing factor in this study was found to be the education on spiritual care.

Priority is to be given to personal spirituality to enhance assessment skills of spiritual needs (Rankin and DeLashmutt, 2006) and to the cultural and religious perspectives to individualise spiritual care (Khademian and Vizeshfar, 2007). Self-awareness of personal beliefs and attitudes through self-reflection is fundamental to foster effective spiritual care within the context of the professional culture (Narayanasamy, 1999; Cone and Giske, 2013). Thus, exposure of students to diverse cultures may enhance their cultural awareness and sensitivity in holistic care (Narayanasamy, 2006).

The complexity of spiritual care incorporates various ethical issues which need to be safeguarded to maintain patients’ dignity and safety (Polzer and Engebretson, 2012). Spirituality needs to be integrated in the nursing/midwifery undergraduate curricula either by an introductory study unit on spiritual care in the first year of the course and followed up academically and clinically across the entire education programme (Giske, 2012; Cone and Giske, 2013) or by an integrated model across the education programme (Callister et al., 2004). The content and pedagogical methods of teaching are of utmost importance for effective teaching and learning spiritual care (Greenstreet, 1999; Taylor et al., 2008) in real-life situations in collaboration with patients, chaplains and multidisciplinary teams and follow-up by continuing professional programmes (Joyce, 2012). Reflection and reflective practice in education enable learners to process and synthesise information from the theory learnt and their clinical experiences applied to holistic care (Oelofsen, 2012).

Limitations

The demographic questionnaire included only three influencing variables, namely, profession, education and time (pre/post-registration). However, other variables may have influenced competency in spiritual care such as the Judeo-Christian orientation of the taught study units to undergraduate and post-graduate nurses/midwives and the dominance of Christianity in health caregivers, of whom 97% are Maltese and 95% of are registered as Roman Catholics. Care in private and state hospitals are supported by chaplains/pastors which is complying with the Malta Code of Ethics (2001), which requests health caregivers to address patients’ needs holistically including the religious and cultural needs. The problem of a huge influx of immigrants in Malta with diverse religions was addressed by the education and management sectors by encouraging the health caregivers to respect and address the diverse needs of clients with different religions. The different types of educational programmes delivered in the published studies limited comparison of these findings to the existing research. The non-significant results of the regression analysis may be due to the small sample in this study. However, these findings shed light on the importance of ‘taught’ spiritual care. Thus, further cross-cultural research is suggested to include a larger sample of nurses/midwives with various religions, cultures and education on spiritual care.

Conclusion

The taught study units to pre- and post-registration nurses/midwives and other possible influencing variables such as life experiences and clinical practice contribute towards acquisition of competency in spiritual care. Therefore, further trans-cultural longitudinal research is recommended to compare the impact of life experiences on care between undergraduate and post-graduate nurses/midwives. Study units on spiritual care as a stand-alone module or threaded into the curriculum are beneficial for nurses/midwives in the provision of holistic care. The educator may have an important role in the learning process, thus preparedness of the educators in the teaching of this dimension of care is necessary at both faculty and clinical practice.

Reflective teaching methodology such as group discussions, critical incident analysis, keeping of diaries, role play, online discussions to allow ongoing mentoring of students beyond class hours and self-reflection are recommended as they enable transfer of learning into clinical practice with the potential of minimising the divergence between the theory and practice of spiritual care.
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