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Spiritual Care Competences among Health Care Professionals in Pakistan: Findings from a Cross-Sectional Survey

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Abstract: Introduction: There is a gap in healthcare literature related to the spiritual competence of physicians and nurses practicing in South Asian Muslim communities. To fill that gap, the Spiritual Care Competence Questionnaire (SCCQ) was applied which was developed to address multi-professional spiritual care competences. Materials and Methods: A cross-sectional study among 294 health professionals (61% physicians, 17% nurses, and 22% other professions) in 10 hospitals in Punjab, Pakistan. Results: The highest scoring competences were "Dealing with patients/Communication competences", while "Team Spirit" scored lowest. There were no gender related differences, but there were effects related to professions. "Team Spirit", "Dealing with patients/Communication competences", and "Empowerment competences" scored significantly higher in nurses as compared to physicians and other health care professionals, while there were no significant differences for their "Perception/Documentation competences". These competences were not relevantly related to the intensity of their prayer/meditation activity. Conclusions: Health care professional from Punjab were preferred to tolerate the pain and the suffering of patients and their relatives rather than to talk about spiritual care issues. Their spiritual care competences were less developed. Thus, there is a clear need for further specific education and training of health professionals.

Keywords: spiritual competence; patients; medical doctors; nurses; Pakistan; questionnaire

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1. Introduction

Understanding individual illness experience has substantial theoretical and practical implications for improving patient care. During illness, the fact how a patient is treated by family, physicians, and nurses has an impact on his/her health attitude and behavior. Illness experience can make a patient vulnerable to distress, and thus influences how the illness is interpreted (Büssing and Fischer 2009). Health crises often make human beings question their life and think too much of their death (Ellis et al. 2013). Complete health care is assumed to be realized when patients' spiritual needs are also addressed, along with their somatic treatment (O'Brien 2003). Several studies have reported unmet spiritual needs (Büssing 2021a) or inadequately addressed spiritual needs (Hodge and Horvath 2011). Patients often report unmet spiritual and existential needs (Büssing 2021a), and spiritual support which prove to be important sources of coping and a better quality of life (Büssing and Koenig 2010). Hospitalized patients demonstrate a desire for spiritual interaction, and they demand their spiritual issues and needs be addressed (Ellis et al. 2013). The results of diverse studies depict a significant relationship between spiritual health and patients' quality of life (Mohebbifar et al. 2015). However, these associations may also depend on underlying disease, culture, and religious orientation.

Spiritual care is a complex process of being aware of a person's spiritual needs, resources, and struggles, and addressing and supporting these by a multi-professional team that may involve health care professionals and chaplains (Büssing 2021b; Nissen et al. 2021). It may involve four main themes: (1) relational, (2) individualistic, (3) embodied, and (4) verbal aspects of spiritual care (Viftrup et al. 2021). The application of spiritual care can help patients to cope with health care problems and find meaning to such health issues (Touhy 2001). A positive frame of mind can help individuals to exhibit healthy behaviors for instance an increase in hope may be a benefit in terms of social support (Coyle 2002). Addressing the spiritual needs of patients may improve healing and coping with pain and reduce stress (Connerton and Moe 2018), although this is not guaranteed as it is also depending on personality issues and disease itself, too (Büssing 2021a).

Patients expect that health care providers should be able to address spiritual needs and struggles (Fitch and Bartlett 2019). Instead of leaving the spiritual care realm completely in the hands of family and of chaplains, health care professionals should actively play their part in addressing the spiritual needs of patients, too (Abdulla et al. 2019). In patients with chronic pain diseases from secular Germany, 37% would like to talk with their physicians about their spiritual/religious concerns (Büssing et al. 2009).

Spiritual care training of health care professionals may have plentiful positive effects on patient care including increased receptiveness and support (Vlasblom et al. 2011). Studies have found that a perception of incompetence, lack of spiritual care training, work overload, lack of time, and unwillingness to deliver spiritual care are major reasons behind unmet spiritual care (Baldacchino 2015). A study on physicians and nurses from 14 Middle Eastern countries showed a low personal sense of being spiritual and not having training as predictors of lack of spiritual care (Bar-Sela et al. 2019). Health care workers consider spiritual care as an important dimension of nursing practice, but they need greater preparedness to provide such care (Chandramohan and Bhagwan 2016). Spiritual care training not only increases spiritual care competency but also enhances the spiritual wellness of health care professionals (Hu et al. 2019). Enhancement of spiritual health not only boosts their personal satisfaction with life but also helps them in providing spiritual care to patients (Mathad et al. 2019). Physicians and nurses are the primary spiritual care providers to patients whose attitude and ability to provide spiritual care to patients have significant effects on patients (Minton et al. 2018). However, spiritual care education is not yet established in the health care settings of most Muslim societies. Only a few studies are available about spirituality in life-threatening conditions in Muslim patients (Asadi-Lari et al. 2008). A review of available studies suggests that despite the voluntary role of mosques and recommendations of religious leaders, spiritual care is not yet institutionalized in Muslim societies. However, Islamic scholars recognize the importance of spiritual care. The Islamic text describes providing prayer conditions, nutritional care, and care of patients in end-of-life as important attributes of spiritual care (Marzband et al. 2016).

Pakistan is a Muslim majority country (97% of the population's religion is Islam), with a highly religious society. The country has the second largest number of Muslims in the world. Religion occupies a central position in the social fabric of the society. Religious beliefs, traditions, and practices are deeply suffused in the psychological, social, and political aspects of life. Studies confirm that patients consider religion and spirituality as a strong source of comfort and coping in health crisis (Sohail 2020). Patients want their physician to pray for them, and they believe that being in the care of "God-fearing physicians" can have a positive impact on health (Ahmed et al. 2012). Despite being from a religious society, doctors are mostly trained to deliver scientific information to patients with little or no focus on the spiritual aspect of one's illness experience. This belief–practice gap poses a barrier in the way of effective doctor–patient interaction and adequate spiritual care.

In fact, there is a huge gap in literature related to the spiritual competence of doctors and nurses practicing in South Asian Muslim communities. The current study is an attempt to fill that gap. For that purpose, we applied the Spiritual Care Competence Questionnaire

(SCCQ) that was developed to address multi-professional self-reported spiritual care competences (Frick et al. 2019). It has been validated so far in Germany (Frick et al. 2019), France (Neves Oliveira 2019), Norway (Mandelkow et al. 2021), and Spanish speaking Latin America (Pastrana et al. 2021), and thus in countries with a Christian background. So far, the instrument has not been applied in a Muslim society. Therefore, we aimed to validate the SCCQ in a Muslim society, and to analyze whether the respective spiritual care competences differ with respect to gender, profession, and spirituality, and how these relate to job related indicators such as hours of work per week and job satisfaction, as previously described. This instrument was developed to address multi-professional self-reported spiritual care competences and validated in multi-professional teams (Frick et al. 2019).

2. Materials and Methods

2.1. Study Design

We performed an anonymous cross-sectional study among health care professionals in more than 10 hospitals in Punjab, Pakistan. The study obtained the Institutional Review of the Institute of Arts and Sciences, Government College University Faisalabad (Chiniot Campus).

2.2. Participants' Recruitment

We applied a convenience sampling method to recruit potential respondents. After receiving permission from the MS (medical superintendent), the local principal investigator visited different departments of hospitals, and they met with doctors and nurses. He explained the purpose of the research. Before starting this survey, the content of the instruments was discussed with six medical doctors in terms of applicability and face validity. There was consensus to apply the questionnaire in the English language because most medical staff in Pakistan are good at the English language. The respondents who agreed to participate anonymously were then provided with the questionnaire.

2.3. Measures

2.3.1. Spiritual Care Competence Questionnaire

The Spiritual Care Competence Questionnaire (SCCQ) uses 26 items scored with a 4-point Likert scale (0—strongly disagree, 1—disagree, 2—agree, 3—strongly agree), and it differentiates in its primary German language version 7 factors: (1) Perception of spiritual needs [5 items; Cronbach's alpha = 0.82]; (2) Team Spirit [5 items; Cronbach's alpha = 0.81]; (3) Documentation competences [3 items; Cronbach's alpha = 0.84]; (4) Spiritual self-awareness competences [5 items; Cronbach's alpha = 0.83]; (5) Knowledge about other religions [2 items; Cronbach's alpha = 0.73]; (6) Conversation competences [2 items; Cronbach's alpha = 0.86]; and (7) Empowerment competences [4 items; Cronbach's alpha = 0.79] (Frick et al. 2019).

Additional items were used as explanatory variables. Among them, four addressed barriers to spiritual care (s44 My knowledge about religion/spirituality is too poor for me to get involved in a competent manner; s46 I do not have time for religious/spiritual topics; s47 No suitable room is available for talking privately about religious/spiritual subjects; and s45 I do not perceive myself as an appropriate person for religious/spiritual subjects). These were combined into an additional factor ("Hindrances") with acceptable internal consistency (Cronbach's alpha = 0.77 in this sample).

In this study, we also validated the SCCQ in participants from Punjab.

2.3.2. Additional Variables

Apart from basic sociodemographic data (gender and age), we also included participants' professions and areas of work, years of employment, working hours per week, and their professional satisfaction (5—point Likert scale: 4—very satisfied, 3—satisfied, 2—more or less satisfied, 1—not satisfied, 0—very unsatisfied).

Further questions addressed religious orientation and whether participants regard themselves as a believing person (3—yes, indeed, 2—yes, somehow, 1—rather not, 0—not at all), and if and how often they meditated or prayed (3—yes, on a regular base; 2—occasionally, 1—rather rarely, 0—not at all).

2.4. Statistical Analyses

Descriptive statistics, internal consistency (Cronbach's coefficient α), and factor analyses (principal component analysis using an Oblimin rotation with Kaiser's normalization) as well as first-order correlations (Spearman's ρ) were computed with IBM SPSS Statistics for Windows, Version 26.0. Given the exploratory character of this study, the significance level was set at $p < 0.01$. The Spearman correlation $r > 0.5$ were considered strong, r between 0.3 and 0.5 as a moderate correlation, r between 0.2 and 0.3 as a weak correlation, and $r < 0.2$ as negligible or no correlation.

3. Results

3.1. Description of the Sample

The sample of 294 participants is more or less balanced with respect to gender (Table 1). Most are Muslims who are praying on a regular level. A majority works as physicians (61%); 17% are working as nurses, and 22% in other professions (psychologists or therapists, and 3 chaplains). Participants' job satisfaction is quite good. All further descriptive data are depicted in Table 1.

Table 1. Description of 294 participants from Pakistan.

	N [1]	% [2]	Mean ± SD
Gender			
Women	152	55.5	
Men	122	45.5	
Age groups			
18–30 years	148	50.9	
31–40 year	124	42.6	
>41 years	19	6.5	
Family status			
Living with partner	171	67.3	
Living without a partner	83	32.7	
Religious orientation			
Muslim	269	91.8	
Christian	22	7.5	
Without religious orientation	2	0.7	
Believing person			
No/rather not	17	3.4	
Yes, somewhat/Yes, definitely	274	94.2	
Praying/Meditation			
Never/seldom	10	2.4	
From time to time	73	24.9	
Regularly	210	71.7	
Profession			
Physician	170	61.2	
Nurse	48	17.3	
Therapist/Psychologist/Chaplain	60	21.6	

Table 1. *Cont.*

	N [1]	% [2]	Mean ± SD
Working area			
Internal medicine	94	31.9	
Surgery/Orthopedics	47	15.9	
Geriatrics/palliative medicine	15	5.1	
Pediatrics	31	10.5	
Gynecology/Midwifery	36	12.2	
Psychiatry/Psychotherapy	19	6.4	
In job since . . . years			
<2 years	76	25.7	
2–5 years	95	32.2	
6–10 years	88	29.8	
>10 years	26	8.8	
Hours of work per week			40.6 ± 17.6
Job satisfaction [0–4]			3.1 ± 0.7
Spiritual care Hindrances [0–3]			1.6 ± 0.6
s16 Feel unpleasant to talk about spiritual issues [0–3]			1.4 ± 0.8
s31 Own spirituality/religiosity has no relevance in my professional work [0–3]			1.3 ± 0.8

[1] In some cases, persons did not provide details of gender, age, etc. [2] Percentages refer to those who provided the respective details.

3.2. Exploratory Factor Analysis

As the SCCQ was so far not applied in a Muslim cohort, we performed an exploratory factor analysis of the data pool, and relied on 252 complete SCCQ data sets. One item had to be excluded due to weak factor loading (s7 "I am able to perceive existential/spiritual needs even if patients have little relation to religion"). The remaining 25 items had a very good internal consistency (Cronbach's alpha = 0.933). Explorative principal component analysis revealed a Kaiser–Mayer-Olkin value of 0.91, which is a measure for the degree of common variance, indicating the item pool's suitability for statistical investigation by means of principal component analysis. The 25 items differentiated in 5 factors with eigenvalues >1.0. These accounted for 63% of the variance (Table 2).

1. The 6-item factor Team Spirit has good internal consistency (Cronbach's alpha = 0.884) and includes the intended items of the primary version.
2. The 4-item factor Dealing with patients/Communication competences has satisfactory internal consistency (Cronbach's alpha = 0.723) and combines items from the primary scale "Conversation competences" scales and two items from other scales.
3. The 7-item factor Empowerment competences has good internal consistency (Cronbach's alpha = 0.842) and includes four of the primary items and additionally two items from the primary scale "Self-awareness and proactive opening" which was not replicated in this study.
4. The 6-item factor Perception/Documentation competences has good internal consistency (Cronbach's alpha = 0.883) includes the intended item of the "Documentation competence" scale and additional items from the primary "Perception competence" scale.
5. The 2-item factor Spiritual Development has a non-satisfactory internal consistency (Cronbach's alpha = 0.533) and should thus not be used. Two other items of the primary scale now load much better on the factor 2 of this study, and this loss of items weakens the factor. Due to this fact, the findings with this scale are depicted in the tables, but they are not interpreted.

Table 2. Factorial structure of the 25-item SCCQ version.

	Mean	SD	Corrected Item/Scale Correlation	Cronbach's Alpha If Item Deleted (0.933)	Factor Loading				
					1	2	3	4	5
Factor 1: Team spirit Eigenvalue: 10.1; Cronbach's alpha = 0.884									
15 In the team, we regularly exchange about our own spirituality	1.4	0.8	0.588	0.930	0.858				
14 In the team, we exchange regularly about spirituality in patient support	1.3	0.8	0.678	0.929	0.792				
17 In the team, we have rituals (for example farewell and interruption rituals) to deal with problematic situations.	1.5	0.9	0.573	0.931	0.681				
12 In our team, we speak regularly about the spiritual needs of the patients.	1.3	0.8	0.710	0.929	0.665				
13 In our institution there is a great openness to the topic of spirituality	1.3	0.9	0.606	0.930	0.655				
8 I can also talk with non-religious patients about their existential/spiritual needs	1.5	0.8	0.524	0.931	0.570				
Factor 2: Dealing with patients and Communication competences Eigenvalue: 1.7; Cronbach's alpha = 0.723									
28 I am able to tolerate the pain/suffering of patients and their relatives.	1.9	0.6	0.348	0.933		0.669			
30 My own spirituality shapes my dealings with others/sick people	1.9	0.8	0.404	0.933		0.662			
19 I am able to conduct an open discussion on existential issues	1.5	0.8	0.666	0.929		0.524			
20 I am able to conduct an open discussion on religious issues	1.5	0.8	0.556	0.931		0.358			
Factor 3: Empowerment competences Eigenvalue: 1.5; Cronbach's alpha = 0.842									
26 I encourage my patients to reflect their spiritual beliefs and attitudes	1.7	0.7	0.550	0.931		0.305	0.757		
42 I regularly approach patients to talk with them about their spiritual needs.	1.4	0.8	0.552	0.931			0.714		
25 In the case of therapeutic decisions, I pay attention to religious/spiritual attitudes and convictions of the individual patient	1.6	0.8	0.639	0.930		0.317	0.662		
35 I pay attention to the appropriate framework for spiritual conversations.	1.5	0.8	0.578	0.930			0.628		

Table 2. *Cont.*

	Mean	SD	Corrected Item/Scale Correlation	Cronbach's Alpha If Item Deleted (0.933)	Factor Loading				
					1	2	3	4	5
24 I enable my patients to participate in religious activities/celebrations	1.5	0.8	0.655	0.929			0.581		
43 I open verbally, but also non-verbally, a 'space' in which the patient may bring spiritual concerns—but is not forced to do so.	1.6	0.7	0.561	0.931			0.541		
38 I am well aware of the religious characteristics of patients from other religious communities.	1.5	0.7	0.591	0.930			0.516		
Factor 4: Perception and documentation competences Eigenvalue: 1.2; Cronbach's alpha = 0.883									
39 I take care that the religious characteristics of patients from other religious communities are adequately considered.	1.7	0.7	0.558	0.931				−0.678	
3 I am familiar with instruments (i.e., topic list) for creating a short spiritual history	1.5	0.8	0.651	0.929	0.391			−0.654	
4 I am familiar with instruments/questionnaires for structurally assessing spiritual needs	1.4	0.8	0.699	0.929	0.314			−0.627	
1 I am confident I can perceive the spiritual needs of patients.	1.6	0.8	0.614	0.930		0.349		−0.618	
5 I know how to document the spiritual history of my patients in a comprehensible way	1.5	0.8	0.681	0.929	0.348			−0.557	
2 I am confident I can perceive the spiritual needs of patients' relatives.	1.5	0.7	0.630	0.930		0.384		−0.495	
Factor 5: Spiritual development competences Eigenvalue: 1.2; Cronbach's alpha = 0.533									
48 I regularly take care of deepening my own spirituality	1.8	0.8	0.331	0.934		0.395			0.751
49 I regularly attend professional development sessions on spiritual topics.	1.4	0.8	0.441	0.933					0.575
Deleted item (too weak factor loading)									
s29 My thoughts and feelings are with the people I accompany	2.3	0.7				x			
7 I am able to perceive existential/spiritual needs even if patients have little relation to religion	1.6	0.8			x				

Extraction method: Principal component analysis Oblimin Rotation with Kaiser normalization (converged in 14 iterations); the five factors explain the 63% variance.

3.3. Intensity of Self-Perceived Competences

The highest scoring items are s28 ("I am able to tolerate the pain/suffering of patients and their relatives.") and s30 ("My own spirituality shapes my dealings with others/sick people."), while the lowest scoring item is found in the Team Spirit scale. Interestingly, all scores are in a similar range of "indifference" between 1.3 and 1.9 (Table 2). Further, Spiritual Care Hindrances was scored as "indifferent", while the additional ("informative") statements that one feels unpleasant to talk about spiritual issues (additional item s16) or that the own spirituality/religiosity has no relevance in their professional work (additional item s31) were scored as rather disagreement (Table 1).

The factor Dealing with patients/Communication competences scored highest in the sample and Team Spirit lowest (Table 3). There were no gender related differences, but effects related to the profession. Team Spirit, dealing with patients/Communication competences, and Empowerment competences scored significantly higher in nurses as compared to physicians and others, while there were no significant differences for their Perception/Documentation competences (Table 3). As 92% of participants are Muslims and 94% are "believing" persons, respective subgroups referring analyses are not reasonable.

Table 3. Spiritual care competences within the sample.

		Team Spirit	Dealing with Patients/ Communication Competences	Empowerment Competences	Perception/ Documentation Competences	(Spiritual Development)
All participants	Mean	1.40	1.71	1.53	1.53	1.61
	SD	0.65	0.56	0.59	0.59	0.64
Profession						
Physicians (n = 155)	Mean	1.34	1.71	1.44	1.51	1.61
	SD	0.61	0.44	0.52	0.52	0.55
Nurses (n = 42)	Mean	1.69	1.98	1.83	1.68	1.73
	SD	0.79	0.73	0.74	0.80	0.83
Others (n = 56)	Mean	1.29	1.52	1.54	1.46	1.52
	SD	0.63	0.66	0.56	0.57	0.69
F value		5.67	8.27	7.78	1.97	1.33
p-value		0.004	<0.0001	0.001	n.s.	n.s.
Gender						
Women (n = 134)	Mean	1.34	1.68	1.53	1.49	1.58
	SD	0.71	0.62	0.61	0.62	0.71
Men (n = 109)	Mean	1.42	1.72	1.51	1.54	1.64
	SD	0.58	0.48	0.56	0.54	0.54
F value		0.88	0.32	0.08	0.041	0.047
p-value		n.s.	n.s.	n.s.	n.s.	n.s.

3.4. Correlations between Spiritual Care Competences and Indicator Variables

All SSCQ factors are strongly interrelated, while they are not significantly associated with Spiritual Care Hindrances (Table 4). The empathy item s29 that one's own thoughts and feelings are with the people one is accompanying was best and moderately related to the factor "Dealing with patients/Communication competences". In fact, this empathy item would theoretically fit to the factor "Dealing with Patients", however, to the detriment of the two communication items (s19 and s20) which would not load on this factor anymore. The resulting 3-item factor would have an unsatisfactory internal consistency (Cronbach's alpha = 0.694), and thus s29 was not included.

Table 4. Correlation analyses.

	Team Spirit	Dealing with Patients/ Communication Competences	Empowerment Competences	Perception/ Documentation Competences	(Spiritual Development)
Team Spirit	1.000				
Dealing with patients/Communication competences	**0.567** **	**1.000**			
Empowerment competences	**0.680** **	**0.612** **	1.000		
Perception/Documentation competences	**0.700** **	**0.608** **	**0.701** **	1.000	
(Spiritual Development)	**0.428** **	**0.397** **	**0.449** **	**0.404** **	1.000
Spiritual Care Hindrances	0.003	0.080	0.012	0.023	0.128
Hours of work per week	0.046	0.094	−0.009	−0.040	−0.030
Job satisfaction	**0.324** **	0.186 **	0.236 **	0.236 **	0.200 **
Believing person	0.098	0.139	0.038	0.047	0.116
Praying/Meditation	0.101	0.087	0.093	0.109	0.176 **
Empathy (S29)	0.250 **	**0.439** **	0.234 **	0.299 **	0.108

** $p < 0.001$ (Spearman rho); moderate and strong correlations are highlighted (bold).

Further, spiritual competence was not related to participants' working time (hours per week) but to their Job satisfaction, particularly Team Spirit (Table 4). With respect to the intensity of prayer/meditation activity, as an indicator of the centrality of their faith in their life, there were no significant associations; also, agreement to be a "believing" person was not significantly associated. As the empathy item s29 is of some theoretical relevance, it is worth underlining that it is neither significantly related to both spirituality items nor to the job related items (data not shown). However, this empathy item is nevertheless related to the perception that my own spirituality "shapes my dealings with others/sick people" (r = 0.35).

4. Discussion

The majority of research on the spiritual competence of health care staff has been conducted in western societies where the majority of the populations are Christian. Hitherto, less attention has been paid to societies with Muslim majority populations. To overcome this, the SCCQ was successfully applied among healthcare professionals in Punjab. This study may add value to the literature by exploring the Punjabi Muslim community which has different sociocultural norms that are distinct from mainstream Muslim populations.

The factorial structure of the instrument has changed a bit when compared to the German (Frick et al. 2019) and Spanish language (Pastrana et al. 2021) versions. Nevertheless, the identified topics are plausible and principally in line with the intended topics of spiritual care competences (Frick et al. 2019). Nevertheless, it was peculiar that in most cases no clear agreement or disagreement with respect to spiritual care competences was provided by the healthcare professionals from Punjab. Instead, clear statements were found only for job satisfaction. The only perceptions with scores > 2 (agreement) were observed in nurses for an attitude of hardening (s28 "I am able to tolerate the pain/suffering of patients and their relatives"; 2.2 ± 0.7) and empathy (s29 "My thoughts and feelings are with the people I accompany"; 2.3 ± 0.7). This specific aspect of empathy was, however, not significantly related to the intensity of praying/meditation as faith associated rituals or to the intensity of being a believing person as a religious attitude. However, this empathy perception was moderately related to the perception that one's own spirituality influences behaviors

towards patients, indicating that empathy is not simply an intention or an attitude but results in behaviors (action) when it is "shaped" by a person's underlying spirituality." A recent study by Hamouda et al. (2021) found that US physicians with a Muslim background who are more empathic will more likely address their patients' spirituality/religiosity, share their own religious experiences and encourage their patients' religious practices than less empathetic physicians. Thus, the own spirituality may influence the way physicians behave towards their patients. Nevertheless, among Muslim physicians from Saudi Arabia more than half would not ask their patients about religious issues–although 91% stated that religion may have a positive influence on health (Al-Yousefi 2012). The author clearly stated that in Islamic countries "medical institutions should work to improve the capacity of medical personnel to appropriately address religious issues" (Al-Yousefi 2012). This recommendation can be underlined with the current findings from health care professionals in Pakistan.

The highest scoring competences were *Dealing with patients/Communication competences*, which were highest in nurses, while *Team Spirit*" scored lowest. These *Team Spirit* issues address regular exchanges regarding the staff's own spirituality, exchange in the team about spirituality in patient support and their spiritual needs, and a "great openness" to the topic of spirituality. This may indicate that the participants are not used to addressing these issues and may feel unfamiliar to doing so. Another profound reason for avoiding discussion of religious/spiritual views is a sectarian divide in Pakistan society. On workplaces, people try to avoid such discussion which may lead to social conflicts. As a recent study reported, although health care professionals believe that spirituality plays an important role in a patient's illness, only a minority asks patients about spiritual concerns—due to lack of time and considering it as private matter (Jawaid 2020). Findings from Germany (Lee and Baumann 2013) and the USA (Curlin et al. 2007) indicate that medical doctors do not address these topics because 'professional neutrality' is a most important reason, followed by a lack of time and a lack of knowledge, while general discomfort and a lack of "responsibility" were mentioned less often.

In contrast, in this study health care professionals stated that they are able to tolerate the pain and suffering of their patients, as they may assume that this is part of their professional life. However, they also assume that their own spirituality shapes their dealings with others/sick people, even when they may feel unfamiliar to talk about these issues. Nevertheless, staff's responses indicate that they take care that the religious characteristics of patients from other religious communities are adequately considered, indicating that they see these issues as important in a hospital setting. Yet, talking about one's own spirituality with others in the teams may be either too private, or a matter of hierarchic difference between the professions.

While there are no significant gender-related differences in the respective spiritual care competences, there are significant differences among the professions in several topics (*Dealing with patients/Communication competences*, *Empowerment competences*, *Team Spirit*). These differences are not that strong but nevertheless significant. It seems that nurses (as a profession) may be more open to these issues as compared to physicians or other health care professionals. Maybe nurses are more often confronted with situations where they have to talk about these issues during their job routine or they were better prepared during their professional training, while doctors are more trained to treat diseases and apply remedies. In fact, a recent study found that nurses have significantly better opinions about interprofessional collaboration compared to physicians (Kaifi et al. 2021). It can be inferred that nurses appear to have a better appreciation of the significance of patient care and management. In another study (Jalil et al. 2017) in Punjab, patients' reported hesitation in asking questions of their doctors. Uneducated patients frequently mentioned that their questions and requests for repetition annoyed the physicians. Therefore, when health care professionals in general and physicians in particular are not providing necessary time frames and adequate space (rooms) to discuss spiritual matters, it is difficult to convince patients that they can talk about these issues, too.

Interestingly, the hindrances to address these issues were not correlated with staff's spiritual care competences, and also the respective indicators of spirituality were not significantly related to these competences. This means (1) that there is no bias that exclusively religious people will have more of these competences (because of their religious practices), while those who are less strict in their religiosity may nevertheless have similarly high or low competences, and (2) that structural or organizational hindrances are not necessarily affecting staff's spiritual care competences.

5. Conclusions

This study shows that health care professionals in Punjab stated that were able to tolerate the pain and suffering of patients and their relatives, and they may assume this as professional competence, while their spiritual care competences were less developed. As talking about one's own faith, spiritual resources and also religious struggles are regarded as problematic in some religious societies, one may expect a reluctance to talk about and address these issues within the healthcare team and with the patients who are expected to have faith in Allah's will. Health professionals' spirituality may influence how they behave and support their patients in terms of their spiritual needs. Particularly *Team Spirit* in terms of discussing spiritual matters pertaining patients was found to be low, but higher in nurses compared to physicians. Further, nurses showed higher communication competences and empowerment competences as compared to physicians. This could be attributed to their professional education and their direct caring abilities. The current findings from a Muslim society would underline a need for further specific education and training of health professionals. It was surprising that religious participants with quite regular praying/meditation practices are rather 'indifferent' to specific spiritual care competences. The SCCQ could thus be used to evaluate spiritual care education programs, when the aim is to improve these competences to support the patients in a more profound way. Modern health care requires more than caring only for the physical and emotional needs of our patients, and it should also address their patients' spiritual needs and support their faith when it is identified as a resource to cope.

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