

ORIGINAL ARTICLE

A Preliminary Study on The Patients' Experiences in Receiving Spiritual Care At Shari'ah Compliance Hospital

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ABSTRACT

Introduction: Spiritual care has been recognised as a critical component influencing the overall well-being of patients. Previous research suggests that integrating spiritual care into patient management offers multiple benefits, including improved mental health, reduced levels of anxiety and depression, and enhanced quality of life. Although several studies have examined the outcomes of spiritual care interventions, limited attention has been given to understanding the lived experiences of patients receiving spiritual care during hospitalisation. This study aims to explore patients' experiences of spiritual care during their hospital stay. **Methods:** This study employed a qualitative research design. Ten participants were recruited through nominations by healthcare providers who had previously delivered spiritual care. Participants engaged in one-time, in-depth, face-to-face interviews, which were audio-recorded with consent. All interviews were transcribed verbatim and subsequently analysed using thematic analysis. **Results:** Two major themes emerged regarding patients' experiences of spiritual care: (1) Challenges in addressing spiritual needs, and (2) Approaches utilised to deliver spiritual care. The findings reveal that hospitalised patients frequently experience feelings of hopelessness and loneliness. However, compassionate care provided by healthcare professionals significantly contributes to improving their emotional and spiritual well-being. **Conclusion:** Hospitalised patients require not only medical treatment but also spiritual support to promote holistic recovery. Gaining an understanding of patients' experiences is crucial for healthcare providers in delivering effective spiritual care, addressing service gaps, and promoting patient-centred care. Further research is warranted to develop comprehensive strategies for integrating spiritual care into routine clinical practice.

Malaysian Journal of Medicine and Health Sciences (2025) 21(SUPP6):158-163. doi:10.47836/mjmhs.21.s6.27

Keywords: Spirituality, patient, experience, hospital, Malaysia

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INTRODUCTION

Spirituality (Ruhnniyat) in Islam is defined as the presence of a relationship with Allah that influences an individual's self-worth, sense of meaning, and connectedness with others (1). Spirituality is conveyed through key aspects such as connectedness to God, faith, meaning in life, inner strength, love, and hope (2). Spiritual care, meanwhile, involves assessing a patient's

spirituality and spiritual needs (3), which may include facilitating prayer, offering religious counselling, or providing access to religious materials. These activities differ from emotional support, as they are specifically linked to religious and spiritual beliefs rather than general psychological assistance. However, they can complement emotional well-being by providing patients with a sense of peace, hope, and connection to a higher purpose. In nursing, spiritual care is a critical component of holistic care, encompassing self-control, human dignity, integrity, and wholeness (4).

Spiritual needs refer to the attitudes, values, and hopes that connect an individual to a higher being, contributing to health benefits, enhanced well-being, and overall life

improvement (5). This indicates that spiritual needs and spiritual care are inextricably linked and both exert a substantial impact on patients experiencing trauma, illness, or despair. As part of holistic care, healthcare team members are required to develop the necessary skills to identify and address patients' spiritual needs (6).

Malaysia's healthcare system is generally well-organised and efficient in terms of pharmaceutical and medical services; however, the aspect of spiritual care remains insufficiently addressed (7). When facing serious or life-threatening illnesses, patients experience an acute need for spiritual support, encompassing elements such as faith, hope, and emotional reassurance (8). In Indonesia, it has been reported that 91% of doctors indicated that their patients sought emotional and spiritual support to aid in healing and to accept the challenges of their illness (9). However, 78.9% of patients did not perform salat while hospitalised, despite it being a crucial component of spiritual practice (10).

These previous studies were conducted in general hospital settings, raising the question of whether similar challenges occur in Shari'ah Compliant hospitals, where all healthcare services are provided according to Islamic principles. Thus, this study is crucial in exploring the experiences of hospitalised patients in receiving spiritual care within Shari'ah Compliant healthcare institutions.

METHODS

Study design and sample

This study employed a qualitative design to enable in-depth understanding by listening to, interpreting, and narrating participants' experiences in a vicarious manner, thereby engaging the reader both emotionally and intellectually (11). A total of ten participants were recruited using snowball sampling. The inclusion criteria were: 1) Male/female; 2) Muslims; 3) Age 18 and above; 3) Admitted at least three days. Meanwhile the exclusion criteria included: 1) Patients who are very ill; 2) Patients on tracheostomy or unable to talk; 3) Patients who have mental disabilities.

Study setting

The study was conducted at Sultan Haji Ahmad Shah Medical Centre @ IIUM (SASMEC @ IIUM), Kuantan - a Shari'ah Compliant hospital (SCH). SCH refers to healthcare institutions where all services are rendered in accordance with Shari'ah principles or Islamic teachings (12).

Ethical Considerations

Participation in the study was voluntary, and written informed consent was obtained from each participant prior to data collection. Confidentiality and anonymity

were maintained throughout the study. Ethical approval was obtained from the Kulliyah of Nursing Postgraduate and Research Committee (KNPGRC) and the IIUM Research Ethics Committee (IREC 2023-058).

Procedures

Data were collected through semi-structured, face-to-face interviews conducted in Malay using a piloted interview guide. The interview questions such as "In terms of your own illness experience, what are the deep questions you find yourself asking these days? What does 'spiritual care' mean to you? Do you think spiritual care should be provided in healthcare? What sort of people could best support you with any deep emotional or spiritual questions you have?" Most interviews took place in a convenience room at SASMEC @ IIUM and lasted between 20 to 40 minutes. All interviews were audio-recorded, transcribed verbatim, and stored securely. Data collection spanned five months, from February to June 2023.

Data analysis

Thematic analysis was employed to analyse the qualitative data. This method involves identifying, analysing, and reporting patterns (themes) within the dataset. There are 6 steps that need to be followed (13). The first step is familiarising with the data. The data that is in audio files will be transcribed first. Then, read through the transcripts and actively observe meanings and patterns that appear across the data set. Next is generating initial codes that represent the meanings and patterns in the data. Identify interesting excerpts and apply the appropriate codes to them. Excerpts that represent the same meaning should have the same code applied. The third one is combining the codes with supporting data where all the excerpts that are associated were put together. The next one is grouping the codes into themes. The fifth one is to review and revise the themes. It is important to ensure that each theme has enough data to support them and is distinct. Lastly, producing the report and the results

Trustworthiness of Data

To ensure credibility, rapport was established with participants to encourage openness and detailed responses. While transferability is limited due to the specific focus on hospitalised patients in a single institution (SASMEC @ IIUM), dependability may be maintained through consistent data collection procedures. Confirmability was supported through member checking; whereby selected participants were asked to review their transcripts to ensure accuracy (14).

RESULTS

Throughout the period of data collection, 10 participants

agreed to participate. Background of the participants are summarised in Table 1.

Table 1: Demographic data of patients

Patient	Age	Gender	Status Educa-tion	Marital Status	Diagnosis	Days of ad-mitted
Patient 1	41	Male	Primary	Married	Spinal cord injury with underlying diabetes and hypertension	41
Patient 2	44	Male	Primary	Married	Fracture of left tibia & fibula	15
Patient 3	47	Male	Primary	Married	1-Septic shock 2-Resolved viral fever	23
Patient 4	39	Female	Second-ary	Divorced	Pancreatic cancer with underlying diabetes, hypertension and hyperlipidemia	33
Patient 5	35	Male	Second-ary	Married	Alleged mva motorbike vs car with fracture of right femur, dislocate right shoulder, laceration wound at left eyebrow and lower lips and multiple abrasion wound over upper and lower limbs	11
Patient 6	38	Male	Primary	Married	1-Meningitis 2-Community Acquired Pneumonia (CAP)	45
Patient 7	40	Female	Primary	Married	1-Fracture of L4, L5 and L6 2-Medial meniscus tear of right knee	18
Patient 8	55	Male	Primary	Divorced	Colorectal cancer with underlying anemia	25
Patient 9	43	Male	Primary	Divorced	Pneumonia with underlying chronic kidney disease (CKD)	40
Patient 10	51	Female	Second-ary	Divorced	Alleged mva motorbike vs car with patella fracture, multiple abrasion wound over face, back, hand and both lower limbs.	13

Through thematic analysis, two themes were identified: 1) Challenges in meeting spiritual needs; 2) Approach used to provide spiritual care.

Theme 1: Challenges in meeting spiritual needs

Hospitalised patients sought spiritual care from both their family members and healthcare providers. Their mental and physical well-being required careful attention throughout their hospitalisation. However, several challenges were identified in delivering spiritual

care to patients. The first challenge was the emergence of negative feelings. Many patients expressed difficult emotions associated with coping with their illness. For instance, P1 shared feelings of hopelessness regarding the possibility of recovery

“feeling hopeless, I will just stare in this room, with nothing in my mind” (P1)

P2 mentioned the loneliness that he felt while being warded and prefer to die.

“I feel depressed, my wife had to outstation, and I am alone here, sometimes I feel that it’s better for me to die” (P2)

P4 stated that she lost hope and even had no appetite for a long time.

“I have no hope to be treated, even I have no appetite for months” (P4)

Many patients reported feelings of hopelessness, with some expressing that they would prefer death over continuing to fight for their lives. In addition, participants highlighted the need for someone to listen to them during their hospital stay. P1 conveyed the importance of having a listener, stating that he needed someone to whom he could express his problems and frustrations.

“I want they listening to my problem, I have a lot of things to be said” (P1)

“I want to express my feelings, but I have no one to talk to” (P7)

P1 and P7 expressed spiritual concerns relating to the need for someone who could listen to their problems and personal stories. In addition to the need for a listener, several patients highlighted the importance of having a companion present with them during hospitalisation. P2 shared his sadness at his wife’s inability to accompany him during his hospital stay.

“I really sad when my wife could not take care of me in ward as she had to outstation” (P2)

P5 mentioned that he feels more comfortable to be assisted by his wife in doing activities in daily lives.

“My wife helped me a lot, for example, if I want to sit up, I prefer her to help me instead of nurses” (P5)

P2 and P5 stated that having a companion in ward is preferable and could ease their daily activities.

Theme 2: Approach used to provide spiritual care

Patients reported experiencing various approaches used by healthcare providers to address their spiritual needs.

P2 shared his experience of receiving spiritual care from nursing staff.

“Nurse attended me as soon after I press the call bell, she helped me and I am very relieved with that,” (P2)

P2 expressed feelings of happiness and satisfaction when a nurse promptly responded to his call bell and provided assistance. The prompt actions taken by the nursing staff were perceived as a positive approach, contributing to a sense of emotional security and improved patient outcomes.

Few patients mentioned positive outcomes after spiritual guidance from healthcare workers.

“I feel better after shariah compliance unit come and visit me” (P1)

“After they (shariah compliance) visit me, I feel happy and remember Allah and be patient with this test” (P5)

P1 and P5 reported feeling relieved and emotionally better following visits from the Shari’ah Compliance Unit. These findings highlight the significance of proactively addressing patients’ spiritual needs, as doing so can lead to beneficial outcomes for their emotional and psychological well-being.

However, P3 reported experiencing predominantly negative attitudes among the nurses in his ward, noting that only one nurse treated him with compassion and respect

“There are few nurses who are too fierce, so far in this ward I just found one female nurse who is really kind to me” (P3)

Statements from P3 describe the importance of approach used by nurses as patients could vividly remember nurses’ ways in treating them.

P8 views nurses as arrogant and highlights the importance of treating patients like their family members.

“Some of them are arrogant, they should not treat me that way, they should treat patients like their family or relatives” (P8)

P8 described the strong emotional connection that patients sought with nurses, highlighting their expectation to be treated as family members. This finding underscores the significance of the approach adopted by nurses in providing spiritual care, as it directly influences patients’ emotional responses and perceptions of their care.

DISCUSSION

This study identified key challenges in providing spiritual care to hospitalised patients in a Shari’ah Compliant hospital, including feelings of hopelessness, loneliness, and the need for emotional support. The majority of patients reported feelings of sadness and stress while coping with their illness. It is not only their physical health that is affected by their condition; their mental and emotional well-being also requires considerable attention. The findings emphasise that spiritual well-being is closely intertwined with mental and emotional health, aligning with overall well-being and quality of life (15). Given that the patients in this study were admitted to a Shari’ah-compliant hospital, the institution’s role in addressing the spiritual needs of Muslim patients is particularly prominent (16).

A significant finding of this study is that patients expressed a strong need for companionship and emotional support, with many reporting feelings of isolation during hospitalisation. The need for a listener and the presence of family members were repeatedly emphasised, underscoring the crucial role of social support in spiritual care. This finding is consistent with prior studies, which show that hospitalised patients often seek comfort through interactions with caregivers, family, and healthcare providers, particularly in religious contexts where communal support holds cultural significance (17,18). In Islamic contexts, where familial bonds are highly valued, the absence of a companion may exacerbate distress, leading to feelings of abandonment or despair. Facilitating family involvement or offering structured emotional support from healthcare staff could significantly enhance patient satisfaction, emotional well-being, and recovery.

Another key issue identified in this study is the role of healthcare providers in delivering spiritual care. Patients reported mixed experiences: while some felt reassured by the nurses’ prompt attention and the involvement of the Shari’ah Compliance Unit, others described negative interactions with nurses, characterising them as inattentive or lacking empathy. This highlights the inconsistency in spiritual care practices within the hospital setting. Previous research has emphasised that healthcare providers play a crucial role in supporting patients’ spiritual well-being, by integrating effective treatment with attention to spiritual, moral, and social dimensions in accordance with Shari’ah principles (19). Patients in this study expressed happiness when healthcare providers responded promptly to their needs and offered assistance on the ward. They valued staff who recognised holistic personhood and delivered

culturally and faith-based spiritual care (20). However, the dissatisfaction reported by some patients suggests that the quality of spiritual care may vary depending on individual healthcare workers' attitudes, training, and workload pressures.

A notable limitation of this study is its reliance on participants from a single hospital. Despite this constraint, the in-depth data obtained through face-to-face interviews enriched the findings and partially compensated for the study's limited scope. Future research could expand the participant base by including patients from a range of healthcare institutions across Malaysia. In particular, studies should encompass public, private, and teaching hospitals, especially those that adhere to Shari'ah compliant practices. Such an approach would enhance the representativeness and generalisability of the findings, providing a more comprehensive understanding of patients' experiences with spiritual care across diverse healthcare settings.

CONCLUSION

Patients require not only medical intervention but also spiritual care to support their treatment and recovery. The absence of spiritual care may adversely affect patients' mental health, inner strength, and sense of hope. The majority of patients in this study reported experiencing negative emotions associated with their illness; however, receiving spiritual care from healthcare providers and the Shari'ah Compliance Unit had a positive impact, facilitating the healing process. Patients consistently highlighted the importance of companionship during hospitalisation, expressing a desire for someone to listen to their concerns and provide emotional support at their bedside. Participants also shared their experiences regarding the fulfilment of their spiritual needs by healthcare providers, noting feelings of happiness and reassurance when nurses responded promptly to their requests for assistance. Positive outcomes were similarly reported following visits from the Shari'ah Compliance Unit. However, some patients expressed disappointment with negative attitudes from certain nursing staff and emphasised their wish to be treated with the warmth and compassion typically afforded to family members.

ACKNOWLEDGEMENT

We thank all participants for their involvement in this study. This research was supported by the Ministry of Education (MOE) through the Fundamental Research Grant Scheme (FRGS/1/2022/SKK07/UIAM/02/4)

CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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