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Future directions of spiritual care where spiritual care providers do not exist: a qualitative study

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Abstract

Introduction Spiritual care is a fundamental aspect of palliative care, addressing the emotional, existential, and spiritual needs of patients facing life-threatening illnesses. However, in Thailand, the integration of spiritual care into the healthcare system remains underdeveloped due to the absence of professional spiritual care providers. This study aims to explore potential models and future directions for spiritual care within the palliative care context, focusing on how such care can be provided in the absence of professional spiritual care providers.

Method This study is a part of the mixed-method project Shoulders to Cry on: Care for spirituality when spiritual care providers do not exist, aimed at exploring spiritual care in settings without professional providers in Thailand. Qualitative in-depth interviews were conducted with 20 experts from palliative care, religious studies, and social work fields. The participants were recruited through purposeful sampling, and the data were analysed using inductive thematic analysis. Transcribed interviews were managed using NVivo software to identify key patterns and insights for future spiritual care models.

Result The analysis resulted in the development of the S.P.I.R.I.T. model, which outlines six essential themes for the future of spiritual care: (1) Spirituality Training Programs, (2) Providers for Spiritual Care, (3) Integrating Spiritual Care into Healthcare, (4) Research and Evidence-based Practices, (5) Interdisciplinary Collaboration, and (6) Transforming Care Systems. The findings suggest establishing structured training programs and interdisciplinary collaboration are crucial for effective spiritual care delivery.

Conclusion The study emphasises the need for integrating spiritual care into Thailand's healthcare system, focusing on education, research, and collaboration between healthcare providers and religious or community figures. The S.P.I.R.I.T. model offers a framework for addressing current gaps, which could facilitate Thailand's palliative care system in better meeting the spiritual needs of patients. Future studies should focus on establishing spiritual care education in palliative care, especially in resource-limited countries, and addressing local contextual obstacles.

Keywords Spiritual care, Palliative care, Healthcare integration, Interdisciplinary collaboration, Spirituality

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Introduction

Spirituality is a fundamental dimension of human life, reflecting how individuals and communities seek meaning, purpose, and transcendence [1]. It is personal but is connected to the moment, the self, others, nature, and the significant or the sacred [2–5]. Spiritual care focuses on the patient's values and beliefs by addressing and seeking the patient's spiritual needs and challenges, particularly when facing a life-threatening illness. It is one of the eight quality palliative and hospice care domains outlined by the National Consensus Project (NCP), a collaborative initiative established to develop standardised guidelines for high-quality palliative care in the United States [6]. Spiritual care enhances healthcare providers' understanding of their patients and strengthens the relationship between patients and healthcare providers [7]. It is also described as care delivered with kindness, compassion, comfort, and gentleness, including physical care, therapeutic and healing relationships that involve going through the process alongside patients, and empathetic communication that involves active listening and allowing patients to express their feelings [8].

Most patients indicated that recognising their spiritual concerns is an important component affecting healthcare decision-making, outcomes, and quality of life [9–11]. Even though spiritual care is an essential component of palliative care, it remains insufficiently recognised by healthcare providers and healthcare systems [12]. Unmet spiritual needs are widely reported in the literature. For instance, a study in Colorado, the United States found that 97% of patients were rarely or never asked about their spirituality in the past year [13]. Pearce et al. found that 91% of advanced cancer patients had spiritual needs, and 67% desired and received spiritual care from their providers. However, 28% of patients received less spiritual care than they desired, negatively impacting their emotional and spiritual well-being [14].

Spiritual interventions such as offering comfort, hope, and meaning were identified in several countries, including the United States, Canada, the United Kingdom, Australia, and Brazil. These countries have contributed to various interventions, highlighting the global relevance of spiritual care in palliative settings. Each country approaches the integration of spiritual care into its healthcare systems differently, reflecting various cultural and institutional influences. This variety underscores the need for tailored approaches in spiritual care depending on regional contexts [15]. In countries such as the U.S. and Canada, healthcare systems have adopted spiritual care models that rely on professionally trained chaplains with defined scopes of practice and competencies to provide tailored spiritual care to patients and families [16–19]. Their roles are integral to the interdisciplinary care team, especially in palliative care settings [20].

In Thailand, the palliative care system is in the stage of preliminary integration, with 566 out of 600 hospitals offering palliative care services [21, 22]. There is no professionally trained spiritual care provider in Thailand. Some family physicians have to provide such care in their palliative care practice, though many do not feel confident [23]. A study focusing on terminally ill cancer patients in Thailand reported moderate to high levels of spiritual care needs and suggested further exploration of the specific barriers that healthcare professionals face in providing effective spiritual care [24]. Spiritual care in Thailand usually focuses on religion and includes religious rituals such as Vipassana meditation [25, 26]. Similarly, in Taiwan, spiritual care for Buddhist palliative care patients has been shown to focus on integrating religious practices with broader spiritual care interventions, addressing emotional well-being and acceptance of terminal illnesses [27]. These shared cultural and religious foundations highlight the potential for leveraging Buddhist practices in designing spiritual care models tailored to local contexts. However, the lack of professional spiritual care providers in Thailand highlights the need to create a well-structured and culturally appropriate approach that goes beyond traditional religious practices to address the varied spiritual needs of patients. It is still unclear how spiritual care can be implemented in the healthcare system in Thailand, where professional spiritual care providers do not exist. This study aims to address this gap by assessing the current situation and exploring potential models and future directions for spiritual care.

Methods

Study design

This study is part of an ongoing mixed-method project titled Shoulders to Cry On: Care for Spirituality When Spiritual Care Providers Do Not Exist, which aims to map spiritual care domains and identify providers in the absence of professional spiritual care specialists. The qualitative phase involved in-depth interviews with experts to determine necessary care domains and who should provide them. These interviews yielded valuable insights into Thailand's palliative and spiritual care situation and suggested potential models. Data from this phase were used to develop a survey for the quantitative phase, which will assess the spiritual care domains received by patients and families in palliative care and identify the responsible providers.

This study re-analyzes data from the qualitative phase to gain insights beyond the primary objectives of the umbrella project. In this study, we adopted an interpretative approach to qualitative research grounded in interpretivism. Following Braun and Clarke's method, we utilised inductive thematic analysis to explore suggestions, potential care models, and future directions

regarding spiritual care in palliative care in Thailand [28]. To comprehensively understand the participants' varied experiences in delivering spiritual or palliative care, employing a qualitative research approach is crucial. This study is grounded in a constructivist ontology and epistemology, which recognise the subjective nature of individuals' reality and knowledge construction, emphasising the need to explore participants' interpretations and meanings. The interpretivist paradigm is appropriated as it highlights reality's socially constructed and subjective nature. It underscores the importance of context and the meanings that individuals or groups assign to their experiences. This study received ethical approval from the Institutional Review Board of Mahidol University, Thailand, on August 23rd, 2024. The reference number is COA. MURA 2024/591. This study adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist, ensuring comprehensive and transparent reporting of the qualitative research process [29]. A COREQ checklist can be found in Supplement file 2.

Settings/participants

This study used verbatim transcribed interviews and their de-identified participants' characteristics from the qualitative phase of the above-mentioned ongoing research. Written informed consent was obtained before the interviews, and participants were encouraged to answer questions according to their comfort level.

Participants were identified through a combination of professional networks, and recommendations from key contacts in palliative care and spirituality-related fields. The recruitment process began with direct outreach to individuals known for their expertise in these areas. Snowball sampling was then employed to include additional participants who met the inclusion criteria, ensuring a diverse range of perspectives. Some participants were known to the interviewers as acquaintances from a professional context prior to the study. This prior acquaintance was limited to work-related interactions and did not extend beyond a professional capacity.

Participants were required to have at least five years of professional experience in spirituality-related fields, including palliative care, religious studies, contemplative education, and social work. Exclusion criteria included individuals with less than five years of experience, those outside the specified professional fields, and those who did not provide consent or withdrew during the study. Participants were contacted using their preferred communication methods, ensuring flexibility and convenience. These interviews were completely transcribed in May 2024. There were no participant refusals or dropouts.

Data collection and processing

The completed qualitative part of the ongoing project used semi-structured interviews based on a predefined interview guide as the primary means of data collection. The interview guide was designed specifically for this study, informed by a comprehensive literature review [30–35]. It was then refined to ensure alignment with the study objectives, which included exploring potential spiritual care models and understanding the current contexts (see Supplementary File 1). The study was conducted in Thailand, with most interviews taking place online via Zoom application to accommodate participants' preferences and ensure convenience. Onsite interviews were conducted in workplace settings, such as hospitals, non-profit organization offices, or religious institutions, providing a familiar and comfortable environment for participants. Interviews were recorded using appropriate devices for on-site and online sessions and were later transcribed. Only participants and interviewers present during the interviews. Interviews ranged from 25 to 50 min.

The interviews were conducted from February to April 2024 by NM, PA, and IW, the authors of this study, all of whom have professional experience in palliative care and qualitative research. All interviewers had no known biases or personal assumptions regarding the research topic. NM is a licensed female medical doctor (MD) and is in the final year of a family medicine residency training program. IW is an experienced male palliative physician and a medical educator in family medicine. PA is a male educator and researcher in contemplative education, who specialized in dying study. All interviewers had prior training in qualitative data collection and analysis, ensuring consistency and sensitivity during the interview process.

To maintain consistency across interviews, all three interviewers attended the first interview to align their approaches and reviewed the transcript of the second interview together to refine the process. A pre-developed interview guide provided structure and ensured that all key topics were consistently covered. Regular debriefing sessions addressed any inconsistencies, and participants' confidentiality was protected throughout. These measures ensured a rigorous and standardized data collection process while allowing for flexibility to explore individual insights. Interview transcripts were not returned to participants for review. No repeat interviews were conducted as sufficient data were collected during the initial interviews to achieve data saturation.

Data analysis

Thematic analysis was employed to systematically identify patterns in the data and gain insights into participants' experiences [28]. Two independent researchers

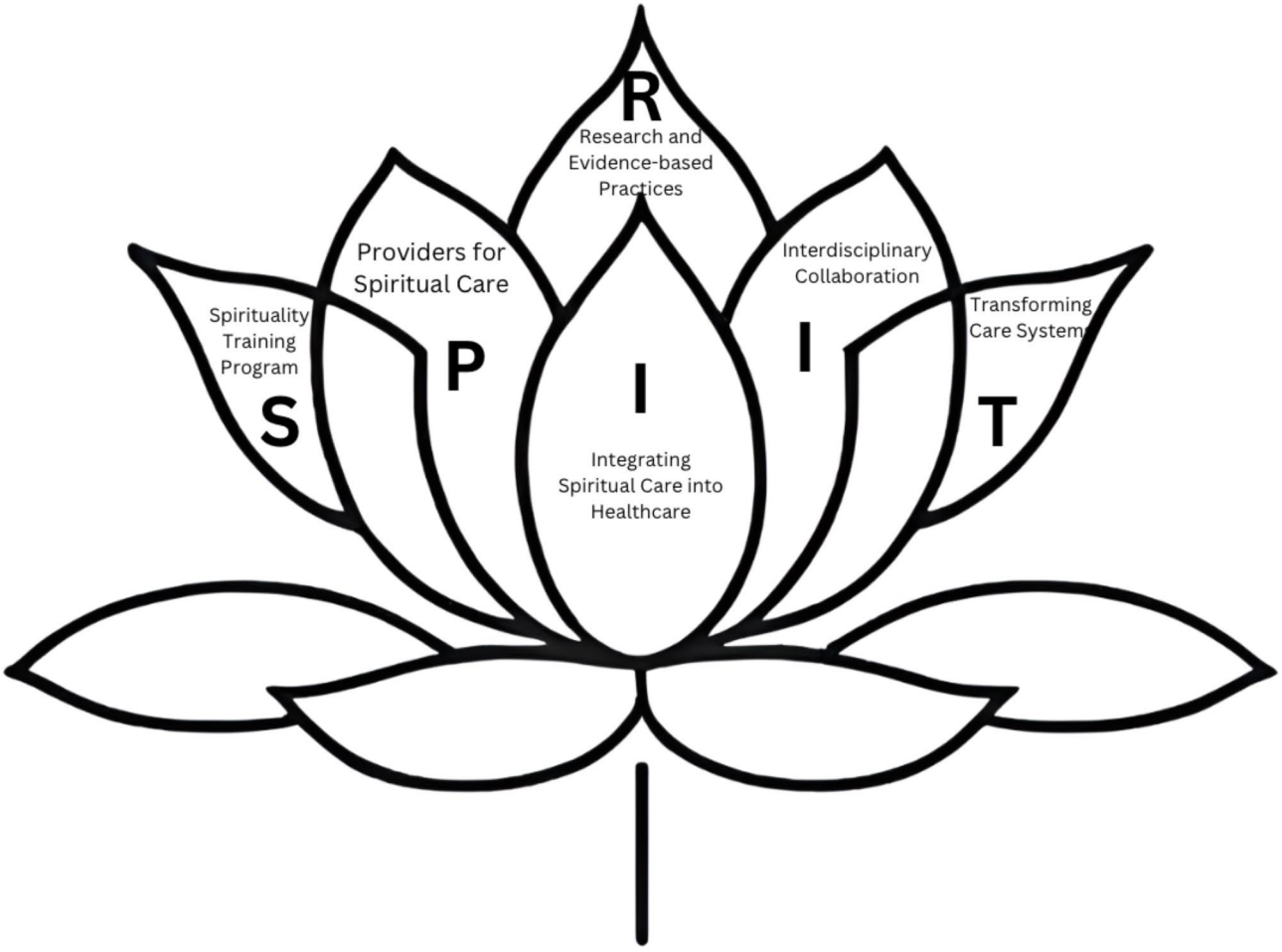

Fig. 1 The S.P.I.R.I.T. model

(NM and IW) coded by generating initial codes from the verbatim transcripts and then organising them into preliminary themes based on identified patterns. The themes were refined through rigorous team discussions and validated by cross-referencing the original data to ensure consistency with the participants' narratives. Data saturation was reached after 18 of the 20 interviews, as ru new themes or sub-themes emerged during the final two interviews. This was confirmed through regular discussions among the research team (NM, PA, and IW) during thematic analysis. This process culminated in the synthesis of a final set of themes. Participants were not asked to review or provide feedback on the study findings. NVivo software was utilised to manage and facilitate sharing transcribed notes (QSR NVivo version 14, 2023).

Results

Twenty verbatim transcripts were obtained for analysis. According to the mentioned ongoing project, the interviews were conducted from February to April 2024. There were twenty experts recruited as participants. Of the 20 participants, 10 were palliative care physicians, 4 were community-based advocates for the death and dying movement, and 2 were Buddhist monks. The remaining participants included a clinical psychologist, a palliative care nurse, a contemplative educator, and a theologist. The participants' ages ranged from 26 to 59 years, with a mean age of 44.3 years. The group was evenly split by gender, with 10 male and 10 female participants. The majority (14 out of 20) worked in hospital settings, while 4 were affiliated with non-profit organizations, 2 with religious organizations, and 1 with a research center. A thematic analysis revealed six themes, as illustrated in Fig. 1.

Emerging *themes: the S.P.I.R.I.T. model*

The data analysis revealed six emerging themes related to future directions in spiritual care provision in a country where no professional spiritual care provider exists: (1) Spirituality Training Programs, (2) Providers for Spiritual Care, (3) Integrating into Healthcare, (4) Research and

Evidence-based Practices, (5) Interdisciplinary Collaboration, and (6) Transforming Care Systems.

The S.P.I.R.I.T. model is symbolized by an unfurling lotus flower, with each petal representing one of the emerging themes, as shown in Fig. 1. All six petals connect to a central petal and stem, symbolizing the current context and healthcare systems. The lotus flower was chosen as it holds profound significance in Asian cultures and spiritual traditions, particularly in Buddhism and Hinduism. It represents purity, enlightenment, and spiritual awakening [36]. The lotus metaphorically reflects the journey from ignorance to wisdom, rising from muddy waters to bloom above the surface [37].

S: spirituality training programs

Spiritual care training programs were highlighted as essential for medical and healthcare students. To effectively learn about spiritual care, learners must first understand its importance and benefits. These training programs should include core components such as the definitions and concepts of spirituality, assessments, management, and essential skills like active listening, effective communication, counselling, and compassion. Palliative care providers, who already possess strong foundational skills, can expand their expertise to include elements of spiritual care. By gaining practical experience in hospital settings and managing complex cases, they can further develop these capabilities, ultimately enhancing their ability to deliver holistic and effective patient care.

> *"At first, when they haven't talked or asked before, they might be hesitant. But after receiving training, like in our department, those who understand the topic and have talked about it become more confident. They feel comfortable talking to patients and are willing to initiate this topic." [P02, male, 46 years old].*

Some participants suggested that specialized training programs may be needed in the future to address complex spiritual needs requiring expertise. Monks and volunteers were frequently identified as candidates for such specialized training to become spiritual care specialists. In contrast, healthcare providers were less commonly expected to assume this role due to their already heavy workloads and staffing shortages.

> *"The important new understanding is that, as healthcare professionals, we already know that in the end, we will have to deal with death. So, the essential skills, beyond just knowledge, are these abilities. If we are to help one another, it involves promoting and providing opportunities for healthcare professionals to access training in these areas and recognise their importance in patient care, not just for terminal patients." [P12, female, 50 years old].*

P: providers for spiritual care

In the absence of professional spiritual care providers, participants believed that both healthcare and non-healthcare providers should take on the roles of spiritual care providers. However, many suggested that spiritual care should first be prioritised within healthcare providers due to their foundational medical knowledge and caregiving skills. Physicians, in particular, were highlighted as highly respected figures in Thai society, with patients often trusting their perspectives and advice. Family physicians were frequently mentioned for their holistic approach and their enduring presence as both the first and last point of care for patients. Nurses were also recognised for their significant role in spiritual care due to their close relationships with patients and their intrinsic understanding of the caring profession. Additionally, social workers, psychiatrists, and music therapists were noted for their contributions to spiritual care.

Among non-healthcare providers, volunteers were seen as a vital resource for the future spiritual care system due to their altruistic nature and ability to devote sufficient time to patient care. Family members and those in the patient's immediate circle were also regarded as essential for promoting spiritual well-being. Religious and traditionally respected figures were identified as crucial in spiritual care, reflecting the diverse faiths and beliefs present in Thai communities. Participants emphasised the importance of involving spiritual leaders from each community to ensure spiritual care is culturally appropriate and effective.

> *"The death of a person isn't the responsibility of just one individual; it's something we all collectively contribute to, helping someone have a good death. So, in terms of spirituality, it could be anyone, right?" [P16, female, 36 years old].*

> *"I believe it's everyone, but each person's role might vary depending on time or other factors. They may not contribute equally, but I think the spiritual suffering of the patient is always present." [P20, female, 35 years old].*

Despite recognising the contributions of various stakeholders, some participants felt that professional spiritual care providers or specialists remain necessary within the healthcare system. These specialists would be better equipped to manage complex cases and deliver spiritual care at a deeper, more tailored level.

"If possible, in the future, I would like to see specialised spiritual providers, because, as I mentioned, there's a certain specificity and depth in this area. People who need this kind of support will have someone who can guide them accurately." [P19, female, 39 years old].

I: integrating spiritual care into healthcare

Integrating spiritual care within healthcare provides comfort and enhances a patient's overall well-being by combining healing practices with medical interventions. When healthcare providers address a patient's spiritual needs alongside their physical health, they can deliver more holistic care, focusing on emotional and spiritual well-being. This integration can be implemented in various areas, including medical education, service delivery, and organisational policy.

"How about incorporating this into medical care? For example, if it's a doctor who cares for palliative patients, they could provide this kind of information. By the time they come to us and we're dealing with terminal patients, they'll already get how they want to design or plan things, stuff like that." [P16, female, 36 years old].

Some participants suggested that incorporating spirituality into health professions training curricula would foster the right attitudes and awareness among future healthcare providers, enabling them to offer basic spiritual care. Others highlighted the importance of allowing or even emphasising specific rituals or activities in routine hospital care.

"They let that uncle (traditionally respected figure) participate in care. That uncle would come to provide some meaningful rituals such as the Bai Sri ceremony, wrist tieing ceremony, and Spirit Welcoming ceremony. It helps, but it's easier to do in a community hospital." [P03, male, 41 years old].

Additionally, organisational policies were mentioned as a means of facilitating the seamless integration of spiritual care into conventional healthcare.

"Other models I've seen are mostly in hospitals that have religious organisations backing them, like Catholic hospitals. They may offer this kind of service as an add-on." [P04 male, 46 years old].

R: research and evidence-based practices

Given the scarcity of spirituality-related research in Thailand, especially in palliative care contexts, spiritual care is a crucial area requiring further exploration to demonstrate its benefits to stakeholders for palliative care and the healthcare systems. Participants viewed that demonstrating the tangible benefits of spiritual care will contribute to firm and deeper integration of spiritual care into the healthcare system.

"We've got to prove the value of having spiritual care and how it impacts patient outcomes or the people around them. And, if possible, how it affects the healthcare system as a whole. If we have that data, I think it could help convince policymakers that spiritual care should be part of the country's main healthcare system." [P04, male, 46 years old].

Through research, healthcare professionals and other spiritual care providers can better understand the impact of spiritual care, how to integrate spiritual care into their practices and refine interventions. This knowledge development promotes more effective training, improved patient outcomes, and the ability to address complex spiritual needs.

"There are people conducting research on these topics, which is important. It's essential that everyone gains the ability to do it, with advisors available to assist when complex cases arise." [P06, male, 46 years old].

I: interdisciplinary collaboration

Participants emphasised the significance of interdisciplinary collaboration as a cornerstone of spiritual care, particularly in palliative care settings. Each healthcare profession addresses patients' holistic needs from a unique perspective, contributing to comprehensive care. For example, psychologists focus on emotional needs and mental well-being, while physicians predominantly address physical concerns. By collaborating to enhance patients' well-being, especially in the absence of spiritual care specialists, healthcare providers ensure that all dimensions of care, including spiritual aspects, are covered. This results in a more integrated approach and improved patient outcomes.

"If every profession or everyone working in this field could view the patient and share information holistically, allowing everyone to see and understand the patient as a whole, it would make the in-depth work of each profession much easier." [P01 male, 26 years old].

Collaboration enables healthcare professionals to share insights, enhancing how spiritual care is incorporated into healthcare practices. Regular discussions and interdisciplinary meetings help providers better understand

the integration of spiritual care within their roles, facilitating the development of effective care plans. This teamwork ensures thorough assessments of spiritual needs, leading to more comprehensive care and improved outcomes, including better patient and family experiences throughout the palliative care journey.

> *"We can all move forward together as a team—patients, caregivers, doctors, nurses, all of us. We need to sense that we are on a shared mission, collaborating to achieve something together." [P08, male, 59 years old].*

T: transforming care systems

Transforming the healthcare system is essential to delivering comprehensive care for palliative care patients, with spirituality being a key component. Addressing system-level obstacles is necessary to enhance the quality of care. Common challenges, such as limited resources, work overload, and health financing difficulties, affect all healthcare sectors. As part of this system, these barriers similarly impact palliative care, including spiritual care. For example, the general shortage of healthcare providers limits the time and personnel available to offer spiritual care to patients and families. Additionally, rigid regulations hinder collaboration with non-healthcare sectors in delivering spiritual care during hospitalisation.

> *"In the end, it might just come down to cost or the infrastructure setup, whether it's the hospital service system or something else. It's quite challenging because dealing with that falls under the system-level issues." [P06, male, 46 years old].*

> *"People who want to volunteer have to register first. They can't just walk in casually like that, you know. It's tied up with bureaucratic procedures, so that makes the issue of death still something confined to the hospital setting." [P05, female, 48 years old].*

To develop or improve spiritual care, participants emphasised the need to transform healthcare systems by establishing a solid foundation and integrating spiritual care into existing structures. This transformation requires the support of hospital administrators and policymakers. First, the significance of spiritual care must be recognized, and only then can its integration into the healthcare system be implemented.

> *"It also depends on the policies set by the executives, something like that. The management needs to understand these matters as well." [P03, male, 41 years old].*

Discussion

The analysis adopts the S.P.I.R.I.T Model, which portrays what participants perceive as future directions of spiritual care where no professional spiritual care providers exist. This model comprises six essential elements: (1) Spirituality Training Programs, (2) Providers for Spiritual Care, (3) Integrating into Healthcare, (4) Research and Evidence-based Practices, (5) Interdisciplinary Collaboration, and (6) Transforming Care Systems.

Roles in spiritual care provision the absence of specialists

The findings highlight that spiritual care provision is a shared responsibility involving both healthcare and non-healthcare providers. Non-healthcare providers, such as spiritual leaders and volunteers, play a vital role as supportive resources for patients and families, offering a welcoming presence and building strong rapport. Within healthcare, every profession contributes uniquely to spiritual care by identifying, assessing, and addressing spiritual needs to varying degrees. Family physicians, palliative care physicians, and nurses occupy a central role, as they are often at the frontline of patient and family care. Consequently, they require foundational competencies in spiritual care to address these needs effectively and to advocate for its integration into healthcare practices.

Our analysis aligns with previous studies, highlighting that interdisciplinary collaboration, a key aspect of palliative care, also plays a vital role in providing spiritual care [38–40]. Models proposed in various contexts, including by spiritual care specialists and a Korean study, highlight the roles of physicians, nurses, and social workers in providing comprehensive spiritual care [41, 42]. Therefore, the spirituality training programs proposed in our model align with previous studies, which have widely emphasized their importance [42–47].

Barriers to spiritual care and strategies to overcome

Our model is rooted in current challenges and suggestions for providing spiritual care, identifying common barriers such as limited education, insufficient competencies, and resource constraints. These issues are frequently discussed in the literature. Limited education and insufficient competencies encompass difficulties initiating conversations about spirituality, general communication skills, lack of awareness, and limited self-awareness regarding one's own spirituality [48–51]. Furthermore, many studies identify time and human resource constraints as significant obstacles to spiritual care provision in palliative care, where scarcity is already a challenge [8, 35, 50].

Future directions for spiritual care could face fewer barriers by focusing efforts on implementing spiritual care training programmes. This approach aligns with strategies widely suggested in the literature. For instance,

previous research emphasises the importance of educating healthcare providers about spiritual care and integrating it into healthcare systems [46, 52–54]. The European Association for Palliative Care also highlights the necessity of spirituality education and training in palliative care [44]. Other researchers argue that integrating spiritual care into healthcare systems requires a multifaceted approach, including comprehensively defining spirituality for research purposes, focusing on evidence-based recommendations, and addressing the issue at organisational and policy levels [55–57].

As spirituality is highly context-specific, spiritual care provision must be rooted in cultural practices. Although Thailand is officially a secular country, Buddhism significantly influences Thai people, including healthcare providers. It is therefore essential to consider the influence of Buddhism and other religious traditions when implementing spiritual care models, while ensuring spirituality is not reduced solely to religious practices. Researchers have proposed promoting spiritual care education by acknowledging and incorporating local cultural and religious contexts, such as Karma and Buddhism-based interventions [31, 58, 59]. A Thai study proposed a model that incorporates collaboration with Buddhist monks and Buddhist principles, such as meditation and merit-making, to support a peaceful end-of-life experience [60]. This approach aligns with a study in Taiwan, where Buddhism is also widely practised [27].

Limitations

The findings of this study should be interpreted with caution for several reasons, including participants' backgrounds and the absence of professional spiritual care providers. First, most participants were healthcare professionals working in hospital settings. Although they were familiar with or specialised in death, dying, and palliative care, their perspectives may be heavily influenced by medical considerations. Including participants from non-healthcare fields could yield broader perspectives and more comprehensive approaches. Second, this study was conducted in a country without professional spiritual care providers within the healthcare system. As such, most healthcare providers, particularly those in palliative care, have limited experience collaborating with professional spiritual care specialists. Their perspectives on the roles of specialists and specialised training might differ in a context where such professionals are more integrated into care teams.

Implication and future research

Educational stakeholders can utilise the S.P.I.R.I.T. model of spiritual care to enhance, broaden, and integrate spiritual care practices. Educational institutions can adapt the model to prepare healthcare professionals with core competencies to address the spiritual needs of patients in palliative care. The model also offers policymakers strategic guidance, helping to define organisational or person-related challenges and prioritising solutions to incorporate spiritual care effectively.

Additionally, the model provides a framework for evaluating spiritual care in regions without established professional spiritual care providers. Its themes enable stakeholders to identify specific gaps and barriers, facilitating the development of targeted strategies to integrate spiritual care into palliative services. By addressing these challenges, healthcare systems can better meet patients' comprehensive needs, ensuring their spiritual well-being is an integral part of care.

Future research should focus on developing and evaluating educational programmes on spiritual care in palliative settings, particularly in resource-limited contexts. Exploring current obstacles specific to local contexts would further aid in tailoring strategies for implementing spiritual care.

Conclusion

The study underscores the importance of spirituality in palliative care and strengthens the case for its integration into Thailand's healthcare system. The absence of professional spiritual care providers presents both challenges and opportunities to explore alternative models, such as the proposed S.P.I.R.I.T. model. This model advocates for training healthcare providers in spiritual care, fostering collaboration among practitioners, and integrating spirituality into existing care systems. In the Thai context, where spiritual care is less established than in some countries, the study offers preliminary solutions, such as developing evidence-based strategies, enhancing educational activities, and engaging religious and community leaders. However, further efforts are required to address significant challenges, particularly in training healthcare providers and culturally adapting spiritual care services to fit the local context.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12904-025-01658-w.

Supplementary Material 1

Supplementary Material 2

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None.

Author contributions

NM wrote the proposal, conducted and transcribed interviews, analysed the result data, and wrote a manuscript. IW revised the proposal, analysed the result data, and revised the manuscript. PA conducted interviews and analysed the result data, and AC discussed the study design, revised the

research protocol, and revised the manuscript. All authors read and approved the final manuscript.

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Data availability
The datasets generated and analysed during the current study are not publicly available due to participants' privacy and the sensitive nature of collected data, but they are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
This study received ethical approval from the Institutional Review Board of Mahidol University, Thailand, on August 23rd, 2024. The reference number is COA. MURA 2024/591. All participants provided informed consent prior to their involvement in the study, and steps were taken to ensure the privacy and confidentiality of their data.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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