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Critical appraise of inter-professional clinical practice guidelines for the spiritual care of patients with chronic illness: a systematic review

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Abstract

Background Clinical guidelines for spiritual care play a crucial role in ensuring standardized care for patients with chronic illnesses. The development of these guidelines is complex and necessitates comprehensive evidence; therefore, a critical appraisal of existing guidelines is instrumental in summarizing and aiding the integration of evidence-based knowledge for healthcare providers, as well as in adapting clinical guidelines to local contexts. This study was designed and executed to address the question: "What constitutes the structure and content of an appropriate guideline for inter-professional spiritual care for patients with chronic illness?"

Method This systematic review involved searching the databases of esteemed guideline developers and registrants, including the Agency for Healthcare Research and Quality, the International Guidelines Network, the National Institute for Health and Care Excellence, the National Guidelines Clearinghouse, the New Zealand Department of Health, the Scottish Inter-University Guidelines Network, the National Health Service, the Royal Flying Doctor Service, the National Consensus Project, the Comprehensive Cancer Centre/Netherlands, and various international databases such as Science Direct, PubMed, ProQuest, CINAHL, the Cochrane Library, Elsevier, and MEDLINE, covering the period from 2007 to 2024. The primary outcome of this research is the evaluated quality of the clinical guidelines. The quality of the guidelines that satisfied the inclusion criteria was evaluated using the Assessment of Guidelines, Research, and Evaluation II (AGREE II) tool by two teams of five inter-professional experts from fields including medicine, nursing, psychology, and spiritual counseling, along with two independent raters. Descriptive statistics were employed to quantify the quality of the guidelines. The secondary outcomes of this study included the titles of the clinical recommendations provided. Any contradictory or duplicate recommendations across the guidelines were compared. A narrative synthesis was also provided to elucidate the findings associated with each guideline.

Results This study critically evaluated 8 clinical guidelines. Utilizing the AGREE tool for the assessment, the guidelines titled Spiritual Care Matters, Spiritual Care guideline, and Religious and Spiritual Care of Patients achieved acceptable scores across all 6 domains of the tool and are strongly endorsed. The content review of these guidelines highlighted similar care practices, including methods for gathering a spiritual history, ways to offer spiritual support to patients

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through family and healthcare teams, effective communication principles with patients, and assisting patients in coping with grief and loss, emphasizing the importance of collaboration among medical, nursing, psychological, and spiritual professionals. The differing care approaches primarily focused on the religious aspects of patient care.

Conclusion The existing guidelines for inter-professional spiritual care for patients with chronic illnesses exhibited variability in methodological quality and fell short of the required standards for rigor in their formulation. Additionally, there was a lack of cohesive guidance on various aspects of spiritual care. There is a pressing need for enhanced efforts to deliver clear, high-quality evidence and greater transparency among guideline developers, particularly regarding the intricate and abstract nature of spiritual care.

Keywords Inter-professional relation, Clinical practice guidelines, Spirituality, Patient, Chronic illness, Systematic review

Introduction

Currently, individuals suffering from chronic illnesses have become a significant health concern. The four primary categories of these diseases encompass cardiovascular diseases, chronic respiratory diseases, cancer, and diabetes, which collectively result in over 41 million deaths globally each year [1]. Living with a chronic illness presents a challenging situation for patients. These individuals often require regular medical visits to access necessary care services. To provide effective treatment and support for these patients, a comprehensive approach is essential, one that takes into account all facets of human health, including physical, psychological, social, and spiritual dimensions. Regrettably, the spiritual aspect frequently receives inadequate attention [2].

The spiritual dimension holds significance for all individuals, regardless of their beliefs [3]. The interpretation of spirituality influences how patients perceive their current health conditions. This perception can differ based on factors such as the individual's faith, the severity of their illness, life crises, spiritual satisfaction, commitment to religious practices, and the extent of social support available [4]. Recognizing the critical role of spirituality in patient care, the World Health Organization has emphasized the importance of spiritual care as a fundamental component of holistic care within its international ethical guidelines [5].

Spiritual care encompasses the process of assisting individuals with the spiritual aspects of their lives, which includes recognizing and addressing the spiritual needs of patients or those experiencing crises. This form of care enhances the quality of life, aids in the healing journey, and assists individuals in discovering meaning and purpose in their existence [6]. Spiritual care enables patients to confront crises brought on by illness and to manage feelings of anxiety and loss. It involves addressing the religious needs of patients, such as facilitating religious rituals and worship, clarifying their relationship with God, utilizing religious texts, and offering psychological support that includes empathy, fostering hope, encouraging emotional expression, actively listening to patients, and providing a sense of availability, acceptance, and respect [7].

Conversely, spiritual interventions are specifically tailored actions aimed at fulfilling spiritual needs, which may involve spiritual counseling, meditation, and various spiritual practices. The key distinction between the two lies in the fact that spiritual care represents a broad and holistic approach, whereas spiritual interventions concentrate on specific spiritual techniques and activities [6]. Addressing the spiritual needs of patients contributes to a heightened sense of survival; it bolsters and enhances their morale, resilience, and capacity to manage physical challenges; and it fosters acceptance of death [8]. When planning for spiritual care, it is essential to identify who can deliver this care and how the spiritual needs of patients can be recognized and addressed [9].

On this basis, spiritual care necessitates a care team that effectively addresses and responds to the religious, spiritual, psychological, and supportive issues associated with the patient's current condition, which has caused distress for both them and their family. The health team should ascertain the patient's viewpoint regarding the current situation, their hopes, fears, the meaning of life, emotions, support resources, and personal beliefs through suitable inter-professional collaboration among the physician, nurse, psychologist, and spiritual counselor, and subsequently design a patient-centered care plan tailored for each individual patient [10].

Achieving such a goal appears to require access to a documented and standardized care framework, such as a clinical guideline, which can not only evaluate the spiritual needs of patients but also coordinate care and offer guidance for caregivers.

Clinical practice guidelines act as facilitating tools to enhance the quality of healthcare, minimize performance variability, and evaluate the effectiveness of health teams [11, 12]. Furthermore, clinical guidelines improve knowledge and skills while fostering a leadership role in those providing care, thereby achieving competence in delivering spiritual care [13]. In delivering spiritual care to patients with chronic illness, the health team must

employ clinical guidelines that take into account professional principles and societal traditions, as well as the essence of spirituality and what equips individuals to cope with a limiting illness [14].

The development of clinical guidelines requires specific facilities and conditions. In countries like Iran, where there is less available evidence, this goal can be achieved by evaluating and critiquing existing guidelines to find the best guideline that encompasses all aspects of standard care provision. The main outcome of this systematic review is to critically evaluate inter-professional clinical guidelines for the spiritual care of patients with chronic illnesses, as well as to identify and analyze the strengths and weaknesses of these guidelines in providing spiritual care. This research can help in identifying best practices and effective strategies in spiritual care and provide scientific evidence to support these guidelines. Given the diversity of approaches and the need for reliable evidence, a systematic review can offer a common framework for inter-professional teams and identify gaps in their knowledge and skills. This comprehensive and documented understanding of the current state of clinical guidelines will aid in improving the quality of care for chronic patients and can lead to the development of new standards in this domain. Accordingly, this study was designed and conducted to answer the question: "What is the structure and content of an appropriate guideline for inter-professional spiritual care of patients with chronic illness?"

Materials and methods

In this study, an integrated review was performed following the methodology outlined by Toronto and Remington (2020) [15]. The PRISMA-2020 checklist was utilized to enhance the clarity and thoroughness of the reporting [16]. Initially, the research question was established. Utilizing the design criteria based on the research question (PICO), the target population for the study is defined as "patients with chronic illness," while the intervention being investigated is "inter-professional spiritual care."

Table 1 Search terms and synonyms, along with their combinations

Population	Concept 1	Concept 2	Context
"Chronic illness" OR " Chronically Ill"	"Inter-professional collaboration " OR "Interprofessional" OR "Interdisciplinary" OR "Multidisciplinary " OR " Multiprofessional " OR Team	AND "Spiritual care"	"Clinical Practice Guideline" " Care Plan* NOT Best Practice Not Protocol Not Pathway

This intervention is analyzed and compared through a critical evaluation of the "spiritual care guidelines with study inclusion criteria." The anticipated outcome of this research is to achieve "the optimal structure and content of clinical guidelines for inter-professional spiritual care for patients with chronic illness." Subsequently, a systematic search of scientific databases was carried out to locate relevant clinical guidelines. The identified clinical guidelines were evaluated using the AGREE II tool. The content of the guidelines deemed appropriate was reviewed, and its connection to the existing literature was interpreted. Ultimately, the findings were presented in a structured format. The specifics of the implementation method are detailed below.

Systematic search

To identify clinical guidelines pertinent to inter-professional spiritual care for patients with chronic illnesses, a systematic search was carried out in the databases of esteemed guideline developers and registrants, including the Agency for Healthcare Research and Quality, the International Guidelines Network, the National Institute for Health and Care Excellence (NICE) (https://www.nice.org.uk/), the National Guidelines Clearinghouse (NGC) (https://www.ahrq.gov/), the New Zealand Department of Health, the Scottish Inter-University Guidelines Network (SIGN) (https://www.sign.ac.uk/about-us/timeline/), the National Health Service (NHS) (https://www.nhs.uk/), the Royal Flying Doctor Service (https://www.flyingdoctor.org.au/), the National Consensus Project (https://www.nationalcoalitionhpc.org/ncp-guidelines/), the Comprehensive Cancer Centre/Netherlands (IKNL) (https://iknl.nl/en), and various international databases such as Science Direct, PubMed, ProQuest, CINAHL, the Cochrane Library, Elsevier, and MEDLINE. The systematic search utilized a combination of English language keywords. The search terms included "Chronic illness", "Spiritual care", "Inter-professional collaboration", "Clinical guideline", along with their synonyms. These keywords were combined with logical operators (AND, OR) and were further expanded through subject heading mapping (Table 1). The search process involved a manual review that was consistently performed across all relevant databases and websites. Mendeley software was employed to manage the citation flow.

Selection criteria

In the quest for existing clinical guidelines, factors such as their relevance to the spiritual care of patients with chronic illnesses who adhere to monotheistic religions, the year of inter-professional guideline creation, the language of the publishing or developing source, and the credibility of the institution that produced the clinical guidelines were taken into account. Evidence published

Table 2 Attributes of expert panel members

Degree	Education Level	Count	Workplace
Physician	Professional Doctorate with a specializing in Internal Medicine, Psychiatry, and Oncology	3	Treatment and Charity Centers, Palliative Care Center
Nursing	Ph.D.	5	Nursing Schools
Psychology	Master's Degree	1	Charity and Counseling Centers
Spiritual counselor	Ph.D. in Comparative Theology, and Law	3	Islamic Research Centers, Religious Studies and Law Schools, Charity Centers

from 2007 to 2024 was scrutinized, with a preference for evidence that provided recommendations and actions for spiritual care at the bedside, particularly those developed through systematic reviews or meta-analyses. It is important to highlight that the choice of the time frame for searching guidelines since 2007 is attributed to scientific advancements and the emergence of new models in spiritual care for chronic patients during this period, which have aimed at enhancing the quality of care and addressing the cultural and religious diversity of patients [17]. Furthermore, the exclusion of non-monotheistic religions stems from the emphasis on guidelines that specifically cater to the spiritual needs of patients within the context of monotheistic religions, thereby facilitating a more effective integration of spiritual care in this setting, as evidence indicates that monotheistic religions significantly influence the treatment process and the quality of life of patients [17]. The limitation of the English language as a potential bias may affect the availability of diverse and comprehensive guidelines, as non-English sources could offer valuable insights. Nevertheless, the selection of English guidelines, owing to the extensive and high credibility of scientific sources in this language, enabled us to concentrate on reliable and current documentation; thus, the criterion of the English language was deemed relevant in this study.

Quality assessment of the guidelines

In evaluating clinical guidelines, the quality, relevance, writing style, content, and scope were examined using the AGREE II tool by two teams of five specialists each, including internal medicine experts, psychiatrists, oncologists, nursing professionals, psychologists, and spiritual advisors. All specialists had a minimum of three years of experience working with patients who had chronic respiratory, cardiovascular, diabetic, and cancer-related conditions. These individuals were purposefully selected and invited to participate in the study, provided they were willing and had the time to collaborate. Participants had the option to withdraw from the research if they chose not to continue. Each team conducted a critical evaluation of four guidelines. The attributes of expert panel members in Table 2.

To control for the risk of bias and the risk of bias due to missing results, as well as for confidence in the body of evidence for an outcome, two research specialists (MM, AI) independently reviewed all the guidelines. The reliability between the two independent raters was measured using the Cohen Kappa test, which indicated an acceptable level of agreement with a coefficient of 0.8. Prior to commencing their evaluations, the assessors participated in a briefing session and received training on the use of the AGREE II tool. This tool serves as a standard method for critiquing and appraising clinical guidelines, assisting the healthcare team in evaluating a clinical guideline before implementing its recommendations. The criteria within this tool are divided into six domains: scope and purpose, stakeholder involvement, rigor of development, clarity and presentation, applicability, and editorial independence. The AGREE II tool comprises 23 items, with three items in the scope and purpose domain, three items in the stakeholder involvement domain, seven items in the rigor of development domain, four items in the clarity and presentation domain, three items in the applicability domain, and two items in the editorial independence domain. Each clinical guideline is assessed in these six domains using a four-point Likert scale: (1) strongly disagree (2), disagree (3), agree, and (4) strongly agree.

The dependability and accuracy of this tool have been evaluated in earlier research. Terrace (2003) performed a study that confirmed this tool as an international assessment instrument for evaluating the quality of clinical guidelines, with 95% of reviewers deeming this tool beneficial for assessing clinical guidelines. Furthermore, the reliability of the various sections of the aforementioned tool was deemed acceptable, with scores ranging from 64–88% [18].

In order to evaluate the quality and content of the identified clinical guidelines, the scores for each criterion were aggregated, and the standardized score for each domain was calculated manually based on the maximum score possible in that domain using the following formula:

The standardized score of the domain = (Minimum possible score - Achieved score)/(Minimum possible score - Maximum possible score).

Guides that obtained a standard score of 50% or higher in all domains were designated as "Highly Recommended"; those that achieved a standard score of 50% or more in the overall evaluation were labeled as "Recommended with modifications"; and guides that did not reach a standard score of 50% or more in either all domains or the overall evaluation were classified as "Not

Recommended" [19]. The results were displayed in table format.

Results

Search results

A total of one hundred and twenty-eight guidelines were found during the initial search. Following a refinement of the search criteria, 48 guidelines were eliminated. After reviewing the titles and abstracts, an additional 40 guidelines were removed. The remaining 40 citations were evaluated for full-text availability, resulting in the exclusion of 10 guidelines due to the lack of full-text access. The final 30 guidelines underwent a comprehensive review for content, leading to the exclusion of 22 guidelines that were either not clinical guidelines or consensus statements, duplicates, or updated versions of previous guidelines. Ultimately, eight guidelines concerning inter-professional spiritual care for chronically ill patients were included in the evaluation process (Fig. 1).

Features of the guidelines

The Features of the Guidelines are detailed in Table 3. These selected guidelines were published from 2009 to 2015. Among them, six were developed by the National Health System England [20–25], one by the Netherlands Cancer Center [26], and one by the World Organization of the Scout Movement Switzerland [27]. All these guidelines were published within the same timeframe. Six of the guidelines provided recommendations for delivering spiritual care to patients with chronic illnesses ([20, 22, 24–26], and [27]). Two guidelines specifically targeted health care providers [21, 23], and all were based on evidence, funded by various institutions, both public [20–27] and private

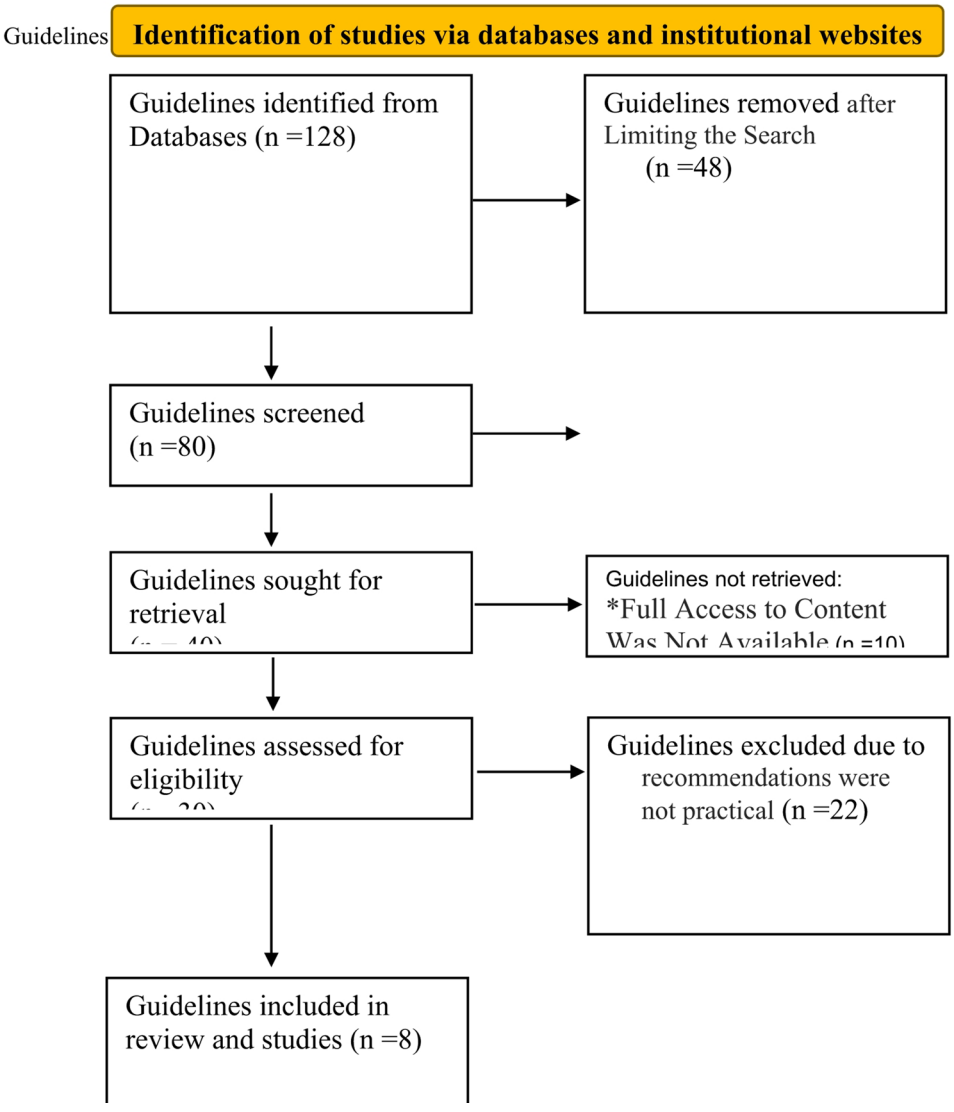

Fig. 1 PRISMA 2020 flowchart illustrating the systematic search process for clinical guidelines

Table 3 Features of the guidelines

Clinical Guideline	Year	Country	Target	AGREE Rigor score	Evidence base	Funding source	Update	Number of evidence
Spiritual Care Matters	2009	UK	Patients with chronic illness	76.66	Systematic literature review	1	Not specified	100
Religious and Spiritual Care of Patients	2012	UK	Patients with chronic illness in end-of-life stages	73.13	Systematic literature review	12	4 times/10 years	Not specified
Spiritual Care Guideline	2009	Nederland	Patients with chronic illnesses with life-threatening illnesses	73.13	Systematic literature review	1	Not specified	64
Spiritual Care and Chaplaincy	2009	UK	patients with chronic illness	66.33	Systematic literature review	3	2 times/7 years	10
Promoting Excellence in Spiritual Care	2014	UK	Care providers	65.8	Systematic literature review	1	2 times/10 years	24
Promoting Excellence in Pastoral, Spiritual & Religious Care	2015	UK	Care providers	65.8	Systematic literature review	1	2 times/10 years	36
Guidelines on Spiritual and Religious Development	2010	Switzerland	Patient with chronic illness	40.93	Systematic literature review	1	Not specified	3
Guidelines for Spiritual Care in Palliative Care	2011	UK	Patient with chronic illness	35.1	Systematic literature review	2	Not specified	4

[20, 22]. None of the guidelines disclosed any conflicts of interest involving the Chairman or other members. The subject headings for these guidelines included Spiritual Care, Palliative Care, End of Life Care, Religious Care, and Psychiatric Care.

Guideline appraisal

Average appraisal scores for the clinical guidelines across the six domains of the AGREE II tool in Table 4. A higher percentage (up to 50%) indicates better quality within the domain. As illustrated in the table, the RSCP, SCM, and SCG guidelines achieved relatively higher scores in most domains [21, 24, 26]. Conversely, the GSCPC and GSRD [25, 27] received low scores across all domains. The SCC and PERSRC [20, 23] scored below 50% in the first domain (vision and purpose), while the SCC and PESC [20, 21] also scored low in the second domain (stakeholder participation), and the PESC scored poorly in the fourth domain (clarity and expressiveness) [21]. Consequently, three guidelines (SCC, PESC, PEPSRC) [20, 21, 23] achieved over 50% in certain domains of the tool and were categorized as "Recommended with modifications," although they were not prioritized for quality assessment. Two guidelines (GSCPC, GSRD) [25, 27] scored below 50% in all domains and were classified in the Not Recommended category. In contrast, three guidelines (RSCP, SCM, SCG) [22, 24, 26] scored above 50% in all domains of the tool, were categorized as "Highly Recommended," and their content underwent qualitative assessment.

Recommendations regarding methods for interprofessional spiritual care for patients with chronic illnesses

Table 5 illustrates that the recommendations derived from the assessment of clinical guidelines for inter-professional spiritual care of patients with chronic illnesses encompassed the consideration of patients' spiritual requirements, religious care, spiritual support, psych-spiritual care, pastoral care, and the nature of inter-professional collaboration. The RSCP, SCM, and SCG [22, 24, 26] addressed all these aspects. These guidelines suggested engaging in conversations with the patient to ascertain their spiritual needs, offering religious care aligned with the patient's religious beliefs and practices, enhancing patient support through family or community support systems, delivering spiritual psychological care by fostering empathy, effective communication, compassion in care, and presence, and providing pastoral care by attributing meaning to life, death, and illness. Furthermore, these guidelines highlighted the importance of conversing with the patient to uncover spiritual needs. The PESC and PEPSRC [21, 23] also outlined religious care with an emphasis on religious practices such as adherence to dress codes, cleanliness, blood transfusions, and dietary restrictions based on the patient's religious beliefs. End-of-life and palliative care received greater emphasis in the RSCP and GSCPC [21, 25]. Spiritual psychological care included the elements mentioned in other guidelines and was particularly emphasized in the PESC, PEPSRC, and GSCPC [21, 23, 25]. Pastoral care, focusing on imparting meaning to life events to foster hope and joy in the patient, was also advocated by PEPSRC and GSCPC [23, 25]. All guidelines underscored the necessity

Table 4 Average appraisal scores for the clinical guidelines across the six domains of the AGREE II tool

Critiqued Clinical Guideline	Expertise critic	Standardized Scores of Criteria (Out of 1 Point)						The overall average score of the guide evaluation
		Independence in Editing	Applicability	Clarity of Presentation	Accuracy and Quality of Methodology	Stakeholder Participation	Vision & Objective	
Spiritual Care Guideline	Physician	0.5	0.78	0.71	0.9	1	1	73/13
	Nurse	0.83	0.53	0.91	0.57	0.5	1	
	Psychologist	1	1	1	1	1	1	
	Spiritual Counselor	0.5	0.54	0.5	0.71	0.41	0.53	
	Spiritual Counselor	0.66	0.54	0.58	0.57	0.5	0.66	
The overall appraisal score averaged in each domains		69.8	74	73	68.2	79.8		Highly Recommended
Spiritual Care and Chaplaincy	Physician	0.33	0.55	0.91	0.9	0.71	0.88	63.33
	Nurse	0.5	0.33	0.58	0.33	0.35	0.66	
	Psychologist	0	0	0.5	0.33	0.83	0.55	
	Spiritual Counselor	0.5	0	0.41	0.42	0.5	0.33	
	Spiritual Counselor	0.83	0.77	0.75	0.66	0.58	0.46	
The overall appraisal score averaged in each domains		0.43	43.2	63	54.2	59.4	60	Recommended with modifications
Promoting Excellence in Spiritual Care	Physician	0.33	0.55	0.73	0.71	0.91	0.91	65.8
	Nurse	0.83	0.11	0.91	0.41	0.58	0.66	
	Psychologist	1	1	1	0.85	1	0.85	
	Spiritual Counselor	0.5	0	0.33	0.09	0.5	0.44	
	Spiritual Counselor	0.66	0.66	0.75	0.66	0.75	0.88	
The overall appraisal score averaged in each domains		66.4	46.4	80.6	49	74.8	77.6	Recommended with modifications
Religious and Spiritual Care of the Patient	Physician	0.66	0.77	0.73	0.8	0.91	1	70.43
	Nurse	0.66	0	0.91	0.23	0.58	0.66	
	Psychologist	0.5	0.54	0.91	0.71	1	1	
	Spiritual Counselor	0.5	0.11	0.58	0.95	1	1	
	Spiritual Counselor	0.83	0.56	0.91	0.61	0.83	0.88	
The overall appraisal score averaged in each domains		63	35.6	80.8	66	86.4	90.8	Highly Recommended
Guidelines for Spiritual Care in Palliative Care	Physician	0.83	0.66	0.83	0.57	0.09	0.66	35.1
	Psychologist	0	0.33	0.33	0.33	0.5	0.55	
	Nurse	0	0.55	0.25	0.23	0.5	0.55	
	Spiritual Counselor	0.5	0	0.16	0.04	0.41	0.33	
	Spiritual Counselor	0.66	0.33	0.16	0.23	0.16	0.22	
The overall appraisal score averaged in each domains		39.8	21.9	34.6	28	33.2	53	Not Recommended

Table 4 (continued)

Critiqued Clinical Guideline	Expertise critic	Standardized Scores of Criteria (Out of 1 Point)						The overall average score of the guide evaluation
		Independence in Editing	Applicability	Clarity of Presentation	Accuracy and Quality of Methodology	Stakeholder Participation	Vision & Objective	
Promoting Excellence in Pastoral, Spiritual& Religious Care	Physician	0.66	0.77	0.83	0.85	0.09	0.88	63.61
	Psychologist	0.66	0.66	0.91	0.76	0.83	0.77	
	Nurse	0.16	0.44	0.41	0.52	0.66	0.77	
	Spiritual Counselor	0.16	0.33	0.41	0.52	0.66	0.77	
	Spiritual Counselor	0.5	0.55	0.66	0.61	0.58	0.88	
The overall appraisal score averaged in each domains		42.8	55	64.4	65.2	56.4	86	Recommended with modifications
Guidelines on Spiritual and Religious Development	Physician	0.5	0.46	0.58	0.33	0.42	0.88	40.93
	Psychologist	0.5	0.33	0.41	0.38	0.41	0.55	
	Nurse	0	0.22	0.16	0.14	0.33	0.66	
	Spiritual Counselor	0	0	0.25	0.04	0.16	0.33	
	Spiritual Counselor	0.5	0.66	0.75	0.61	0.75	0.77	
The overall appraisal score averaged in each domains		0.3	37.4	43	30	41.4	63.8	Not Recommended
Spiritual Care Matters	Physician	0.5	0.88	0.83	0.85	0.86	0.88	76.66
	Psychologist	0.66	0.66	0.66	0.66	0.66	0.66	
	Spiritual Counselor	0.5	0.33	0.75	0.91	1	0.88	
	Nurse	0.66	0.88	0.91	0.81	0.86	0.88	
	Spiritual Counselor	0.66	0.77	0.91	0.76	0.95	0.88	
The overall appraisal score averaged in each domains		59.6	70.4	81.2	80.6	86.6	83.6	Highly Recommended

of collaboration among health team members, including physicians, nurses, psychologists, social workers, and spiritual counselors [20–27].

Discussion

This critical appraisal was carried out in response to the inquiry, "What is the structure and content of an appropriate guideline for inter-professional spiritual care of patients with chronic illness?" This study represents the first critical appraisal guide on this subject. To achieve this, existing clinical guidelines were analyzed using the AGREE II tool. It is essential to employ a standardized method for evaluating and selecting guidelines that are utilized across various organizations, scientific societies, and associations. The aforementioned tool has been validated by incorporating the criteria for the critique and assessment of clinical guidelines [28], as the standards included in the tool can serve as a foundation for evaluating a clinical guide [29]. The primary criterion for critique in this tool involves assessing the perspective and objectives of the clinical guide. The clinical aims, research inquiries, and patient populations addressed by the guidelines are clearly attainable in the selected guidelines [30]. The clinical guideline on Religious and Spiritual Care of Patients received the highest rating based on this criterion. This guideline, developed by the health system of England in partnership with the University of Manchester in 2012, outlines a method for delivering spiritual care to patients nearing the end of life through an evidence-based review. It consists of two sections, which include spiritual care interventions and specific considerations for patients of various religions residing in that country, such as Muslims and Christians. This guide addresses religious and general care aspects, including diet, dressing, hygiene, end-of-life care, family-centered care, and blood transfusions, but it does not encompass psychological care or pastoral or supportive/spiritual care. Furthermore, regarding the religious care of Muslims, additional attention is recommended from the Sunni perspective.

In this guide, similar to the local clinical guide, the assessment of spiritual needs is also addressed.

Table 5 Overview of suggestions regarding Inter-professional clinical practice guidelines for the spiritual care of patients with chronic illness

Objective	Recognizing spiritual requirements and averting spiritual ailments	Religious care	Spiritual support	Psych spiritual care	Pastoral care	Inter-professional collaboration
Spiritual Care Matters	Engaging with the patient	Focusing on the religious beliefs and customs of patients	Highlighting the importance of organizational spirituality	Providing care during bereavement and loss, ensuring spiritual well-being, and facilitating effective communication	Considering the significance of life, illness, and loss	Collaboration among clergy, nurses, doctors, psychologists, and social workers
Religious and Spiritual Care of Patients	Engaging with the patient to identify spiritual issues	Considering the religious beliefs and customs of patients, including dietary restrictions, appropriate attire, emphasis on hygiene, and blood transfusion	practices Family-oriented care	End-of-life support, merging spiritual care with comprehensive physical treatment	Focusing on the significance of life and health challenges	Collaboration among nurses, physicians, psychologists, social workers, and spiritual advisors
Spiritual Care Guideline	Engaging with the patient, crisis intervention, and spiritual assessment	Consideration of the patients' religious beliefs and customs	Focus on current policies	Highlighting the importance of effective communication and attentive listening to the patient	Utilizing the expertise of a spiritual advisor	Collaboration among nurses, physicians, psychologists, social workers, and spiritual advisors
Spiritual Care and Chaplaincy	Engaging with the patient	Focus on Christian religious values	Consideration of the standard ratio of patients to spiritual caregivers across various departments and shifts	Unclear	Unclear: pertains solely to the utilization of chaplaincy services within the hospital	Collaboration between priests, nurses, and doctors
Promoting Excellence in Spiritual Care	Unclear	Unclear	Unclear	Assistance in spiritual matters during critical situations, spiritual guidance for children, and for the community	Unclear	Collaboration between spiritual counselors, nurses, and doctors
Promoting Excellence in Pastoral, Spiritual & Religious Care	Unclear	Consideration of the religious beliefs and customs of patients	Unclear	Consideration of empathy, communication, camaraderie, and the preferences and aspirations of the patient	Consideration of the significance of life, health challenges	Collaboration between spiritual counselors, nurses, and doctors
Guidelines on Spiritual and Religious Development	Unclear	Focus on faith and the influence of religion on life, accompanied by uplifting religious narratives	Unclear	Unclear	Unclear	Collaboration between Scouts and the health team
Guidelines for Spiritual Care in Palliative Care	Engaging with the patient	Unclear	Creating a nurturing atmosphere for spiritual development and resilience, Palliative and End-of-Life Care	Emphasis on compassionate and relationship-focused care	Highlighting meaning, purpose, hope, and a sense of belonging	National Voluntary Consensus

Furthermore, the previously mentioned guide has outlined the role of clergy in fulfilling spiritual needs and their place within the health system [21].

Another aspect of critique in the AGREE II tool is the assessment of the accuracy and quality of the compilation methodology. The Spiritual Care Matters clinical guide achieved a higher score in this evaluation due to its compilation through an evidence review method, the clarity of the relationship between the measures and supporting evidence, and the endorsement of its content by experts outside the compilation group. This guideline, developed by the National Health System of England to

offer spiritual care to hospitalized patients, encompasses information on general spiritual care, religious care, communication, gathering a spiritual history, an overview of spiritual health, reflective practice, bereavement and loss, spirituality with a focus on equality and diversity, organizational spirituality, and the utilization of clergy services. This clinical guideline was created through a review of existing texts and evidence, providing explanatory solutions in the realm of spiritual care while highlighting significant points in each domain and referencing the national policies of that country. In these clinical guidelines, the objectives, questions, and target audience of the guide are delineated as distinct items. This structure can assist users in selecting a clinical guideline for the care and treatment of the target group and aid researchers in citing the evidence of the guide [24]. While several other clinical guidelines have been created in a comparable fashion, it seems that the timeliness and organization of evidence into distinct chapters have made these clinical guidelines more reliable. Since the evaluation of evidence is viewed as one of the most accurate and high-quality approaches in the development of clinical guidelines and aids in their revision based on emerging evidence, this methodology is crucial. Another aspect evaluated by the AGREE II tool is the assessment of stakeholder involvement in the creation of clinical guidelines. In the Spiritual Care Matters clinical guide, specialized groups develop a guide after gathering insights from spiritual care service providers and patients, detailing the roles of nurses, doctors, psychologists, and clergy across various aspects of spiritual care [24]. Systematic research also emphasizes the collaboration of health system personnel and relevant authorities in crafting recommendations and assessing the qualifications of individuals responsible for executing those recommendations to meet the established objectives as a significant factor in the quality of clinical guideline execution [31]. Another aspect evaluated by the AGREE II tool is the assessment of the clarity of the presentation, which again received the highest rating in this criterion of the Spiritual Care Matters clinical guide [24]. Clarity in articulating the recommendations and addressing the outcomes of implementing each recommendation by referencing strategies to enhance the skill level of its users and identifying key care in the selected clinical guidelines garnered the highest scores. The findings of the research also highlight the significance of the clarity of the recommendations in the clinical guide as influential in enhancing the decision-making abilities of users [32] and regard this criterion as a factor that reinforces the validity and robustness of the guide [33].

Applicability appraisal serves as an additional criterion within the AGREE II tool. In the evaluation of clinical guidelines, organizational and behavioral factors, such as barriers and resources for implementing recommendations, the costs associated with applying clinical guidelines, and indicators for monitoring and supervision, are articulated with greater clarity. Nevertheless, the Spiritual Care Matters clinical guide achieved a higher score on this metric. This guideline has been developed for health system personnel by identifying specific authorities in all locations where patients are cared for, with a focus on the cultural and racial diversity present in those regions; it has also incorporated the use of recommendations as part of the organizational responsibilities of users. The previously mentioned guide mandates the employment of consultant clergy in health service centers, with the expenses for these personnel covered by the state health system [24]. Other research has identified numerous factors that influence the ability to implement the recommendations of clinical guidelines; these factors include organizational and cultural disparities, the involvement of specialized disciplines in health service delivery, the availability of essential resources, the individual characteristics of health service providers, the beliefs and values of the target population, and their acceptance. Recommendations have been highlighted among health system employees and patients, emphasizing the importance of considering these factors in the formulation of clinical guidelines [34, 35].

Another criterion in the AGREE II tool is its independence in editing clinical guideline recommendations. In the reviewed clinical guidelines, the sources providing the costs of the guideline compilation have been specified, and it has been noted that there is no conflict of interest between the members of the compilation group. They consider the validity and reliability of the results of a study to be based on the lack of conflicts of interest of the researchers. Additionally, in addition to clarifying the research design policy, the introduction of the research sponsor has been considered a facilitating factor in the exploitation of the results obtained by critics and users of similar organizations [36]. The Spiritual Care guideline, which was developed by the Netherlands Cancer Center in 2009, received the highest score from this evaluation section. This guideline presents how to provide spiritual care to patients with life-threatening diseases by reviewing evidence and conducting qualitative research. In this guideline, four chapters have been designed, including an introduction to spiritual care, prevention of spiritual malaise, diagnosis of spiritual problems, policy, and how to provide spiritual care, and similar to the local clinical guide in the field of spiritual care, it has provided interprofessional measures. The target group of these guidelines is physicians and nurses, and how they cooperate with spiritual counselors, psychologists, and social workers is described, which is also consistent with how users adapt to clinical guidelines; however, the guidelines do not state measures related to each profession separately,

which were not found in any other guide. Additionally, there are no recommendations in the field of preventing spiritual ailments in patients [26].

The findings from this systematic review indicate that clinical practice guidelines are crucial for enhancing the knowledge and skills of healthcare teams. Specifically, when it comes to delivering inter-professional spiritual care to patients with chronic conditions, these guidelines assist team members in gaining a deeper understanding of patients' spiritual needs by offering targeted frameworks and actionable strategies. By fostering communication and empathy skills, team members can engage more effectively with patients, addressing their emotional and spiritual requirements. Additionally, these guidelines can facilitate a culture of inter-professional collaboration, where team members share experiences and knowledge while leveraging diverse expertise. Consequently, this holistic and coordinated approach can elevate the quality of care for chronic patients, making them feel more supported and comfortable. Nevertheless, creating a standardized guideline for spiritual care presents considerable challenges due to the varied definitions and interpretations of spirituality and spiritual care. Spirituality is a nuanced and multi-faceted concept that encompasses religious, philosophical, and personal dimensions. This variation in individual experiences and beliefs complicates the establishment of a clear and all-encompassing definition of spirituality. Moreover, each culture and society may possess distinct attitudes and values regarding spirituality, which can affect the delivery of spiritual care. For instance, in certain cultures, spirituality might be closely linked to religion, whereas in others, it may emphasize more humanistic and philosophical elements. These variations necessitate a flexible and adaptable approach in developing guidelines that cater to the diverse needs of patients.

Furthermore, a lack of consensus regarding optimal practices and methods for evaluating the effectiveness of spiritual care can result in additional challenges. Thus, the development of a standardized guideline that encompasses all these aspects necessitates collaboration and thorough discussions among various professionals, along with a deeper comprehension of patients' needs.

Based on the evaluations of clinical guidelines, it appears that there is a lack of focus on particular domains for enhancement, such as the delivery of existential care, advanced patient-centered strategies, a broader range of spiritual viewpoints, and the incorporation of mixed-methods research in the formulation of guidelines, all of which should be taken into account in the creation of future clinical guidelines pertaining to spiritual care.

Strengths and limitations

Our study encountered several limitations. Firstly, all the clinical guidelines selected were exclusively in English; however, in instances of potential selection bias, some organizations have published guidelines in English even if the official language was not English. Secondly, we opted for the AGREE II tool for assessment and substituted it with other evaluation tools, such as the four-item Global Rating Scale (GRS) [37]. Nevertheless, AGREE II has been utilized in numerous guideline evaluations [38–40]. It remains to be seen whether the findings align with those from other assessment tools, which should be explored in future research. Thirdly, the evaluation conducted using the AGREE II tool was solely based on the general content of the clinical guidelines. This could potentially undermine the objective of guideline appraisal and provide only a broad overview of the guidelines in question. Another limitation of this study is the risk of excluding non-monotheistic guidelines. The search strategy employed for databases and institutional websites also presents a potential limitation. Given that search methodologies may differ across sources (structured searches in databases versus manual browsing of websites), this may have influenced the thoroughness and replicability of the results.

Nonetheless, a significant strength of this study was our decision not to restrict the definition of religion; as a result, the findings may be applicable to researchers and health service providers across various regions, although they cannot be universally applied.

Conclusions

This systematic review aimed to present and critically evaluate the current spiritual care clinical guidelines, which can offer a more comprehensive framework for spiritual care to healthcare providers seeking to enhance the delivery of spiritual care to patients with chronic illnesses and to establish standardized spiritual care practices. Furthermore, this research will benefit those investigating the existing gaps in evidence and adapting clinical guidelines accordingly. The guidelines reviewed exhibited considerable variation concerning the AGRII II criteria. The discrepancies in the studies were associated with the type of religion, the target demographic, and the cultural context of the audience. Consequently, health researchers must tailor spiritual care guidelines to reflect the social, cultural, and religious contexts of their communities by gathering thorough and high-quality data.

Supplementary Information

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Supplementary Material 1.

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Registration information
Systematic review of the registration process in PROSPERO.

What is already known about this topic?

Clinical practice guidelines are essential for standardizing spiritual care.
In addition to physical care, patients with chronic illnesses require spiritual care through inter-professional collaboration among healthcare providers.
The evaluation of global clinical guidelines will assist in determining the most effective guide and tailoring it to each specific region.

Guidelines included
SCC, 2009 [20].
PESC, 2014 [21].
RSCP, 2012 [22].
PEPSRC, 2015 [23].
SCM. 2009 [24].
GSCPC, 2011 [25].
SCG, 2009 [26].
GSRD 2010 [27].

Authors' contributions
All authors listed fulfill the authorship criteria as per the latest guidelines from the International Committee of BMC Palliative Care Journal Editors, and all have agreed to the manuscript. M. Moghimian was responsible for designing the study protocol and data collection forms, drafting the statistical analysis plan, cleaning and analyzing the data, and identifying collaborators involved in data collection and submission. A.R. Irajpour coordinated meetings and oversaw the methodology and data collection. The author(s) reviewed and approved the final manuscript. M. Shams assisted in researching and categorizing the guidelines.

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Data availability
Access to data and research materials can be provided upon request from the journal by Email of the corresponding author **.**.

Declarations

Ethics approval and consent to participate
This research stems from a project sanctioned by the Ethics Committee of Isfahan University of Medical Science in Iran. All participants were informed that their involvement in the study was voluntary and that they could withdraw at any point. They were also guaranteed that their personal information would be kept confidential. Prior to the commencement of the study, informed written consent was secured from all participants. We affirm that all procedures were conducted in compliance with applicable guidelines and regulations.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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