



# Humanistic care provision beyond duty as a new approach to holistic care: a qualitative study

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## Abstract

**Background and aims:** Patients in intensive care unit (ICU) experience not only serious physical problems, but also emotional, psychological, financial, and social problems. Therefore, they need holistic care (HC). The aim of this study was to explore nurses' beliefs about HC provision to patients in ICU.

**Methods:** This qualitative study was conducted in 2019–2020 using the content analysis approach. Participants were sixteen nurses purposively selected from four ICUs of two hospitals affiliated to Isfahan University of Medical Sciences, Isfahan, Iran. Data were collected using face-to-face in-depth semi-structured interviews and analyzed through conventional content analysis. The COREQ checklist was used as a guideline to report the findings.

**Results:** A total of 304 primary codes were generated during data analysis which were grouped into twelve subcategories and two main categories. The two main categories of the study were purposeful nursing care and humanistic care provision beyond duty.

**Conclusion:** Nurses attempt to provide HC and go beyond their assigned duties in HC provision.

**Keywords:** Humanistic care, Holistic care, Nurse, Intensive care unit

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## Introduction

Intensive care unit (ICU) is a clinical setting for advanced care provision to a wide range of patients with acute and life-threatening conditions (1). Admission to ICU is a complex stressful experience (2) and a crisis for patients and their families due to their limited mental readiness. Conscious patients in ICU and their family members experience negative feelings such as fear, shock, anger, guilt, denial, hopelessness, and depression, particularly during the first 72 hours after admission, mostly due to the probability of death or permanent disability, uncertainty about disease prognosis, need for sophisticated medical equipment, emotional conflicts, financial concerns, and unfamiliarity with ICU. Most of these patients experience difficult stay in ICU (3) and report unpleasant experiences such as pain, discomfort, inability to perform daily activities, fatigue, altered consciousness, and sleep disorders (4). A study reported lack of privacy, fear, pain, and environmental noises (2) as the most negative experiences in ICU2 and another study showed pain and ineffective communication with healthcare providers as the main source of distress among patients under mechanical ventilation (4). These problems can delay recovery and cause physical and emotional discomfort for patients and family members (1).

The complicated conditions of patients and their family members highlight the necessity of holistic care (HC) in ICU (1). HC is a comprehensive approach to care delivery which focuses on all physical, mental, emotional, spiritual, social, and financial aspects of health. It improves nurses' understanding of care provision and patient needs and enables them to consider the effects of a disease on all aspects of patients' life (5). According to the American Holistic Nurses Association, holistic nursing includes all nursing practices which heal a person (6). A systematic review reported that HC in nursing improves clients' quality of life and satisfaction in challenging conditions and highlighted the importance of encouraging HC-related beliefs among nurses and removing the barriers to HC (7).

Despite the importance of HC, there is compelling evidence which shows that nurses are trained based on the biomedical approach to care and hence, have limited understanding about HC. Therefore, they mainly focus on their clients' physical needs and mostly neglect their clients' mental, spiritual, moral, and social needs (8,9). A study showed that 64% of patients in ICU wished they could have better communication with healthcare providers and receive sufficient information about their treatment and conditions during their ICU stay, 47% of

them reported they were not offered any choice respecting the care process, 83% of them pleased to be transferred from ICU, and 74.8% of them wanted to completely forget their ICU experience (3). Similarly, a study in the United States showed that 67% of hospitalized patients did not receive HC (10) and a study in the United Kingdom found that only 5% of hospitalized patients received HC (11). A qualitative study in Iran reported lack of staff for HC and lack of private space for communication with patients as the most important barriers to spiritual care provision (12). Moreover, a grounded theory in Iran into the process of patient visitation in adult ICU showed lack of internalization of the holistic approach to care and limited attention to patient- and family-centered care which had led to nurses' greater focus on patients' physical conditions (13).

A key step to HC is to understand nurses' HC-related beliefs. Therefore, the present study was conducted to explore nurses' beliefs about HC provision to patients in ICU.

## Methods

### Design

This qualitative study was conducted from October 2019 to February 2020 using the content analysis approach. Content analysis holds that texts are rich sources of data with great potential to provide valuable information about phenomena (14). It considers both participants and context during data analysis in order to identify similarities, differences, patterns, and relationships in the data and provides a new understanding about phenomena (13).

### Participants and setting

This study was conducted in four ICUs of two hospitals affiliated to Isfahan University of Medical Sciences, Isfahan, Iran. Participants were sixteen nurses with bachelor's, master's, or doctoral degree with a work experience of 1–12 years. Three nurses were head nurse and the remaining thirteen nurses were staff nurse in different work shifts. Two participants had the experience of working at private hospitals. Nurse-patient ratio in all ICUs was 1:2 and all ICUs had restricted patient visitation policies.

### Data collection

Data were collected using face-to-face in-depth semi-structured interviews held by the first author in a private room in the study setting with the careful observance of guidelines for protection against coronavirus disease 2019. The main goal of the interviews was to collect data on nurses' beliefs about HC provision to patients in ICU. Interviews were guided using broad questions about care-related experiences and factors affecting care quality and patient need fulfillment. Examples of these questions were "Can you describe the process of care provision to a patient in ICU?", "In your opinion, what are the needs of a patient in ICU?", "Is your care provision approach for

conscious patients different from unconscious patients?", and "What is your opinion about HC?" Moreover, follow-up questions were used to encourage participants to share more about their experiences, memories, and perceptions. Data collection was continued to reach data saturation, i.e., when no new data were obtained from the interviews. Interviews lasted 60–90 minutes and were audio recorded with participants' permission.

### Data analysis

Data were analyzed through conventional content analysis as proposed by Graneheim et al (15). Accordingly, interview transcripts were read and coded and the codes were compared and grouped into subcategories and main categories based on their similarities. Given the potential effects of data analysts' assumptions on the data, findings, and conclusions (16), reflexivity was used in the present study to put aside assumptions during data collection and analysis (17).

### Trustworthiness

The four criteria of Lincoln and Guba, i.e., credibility, dependability, confirmability, and transferability, were used to ensure trustworthiness (15). Credibility was ensured through prolonged engagement with the study subject matter and the data as well as member checking by some participants. Moreover, peer debriefing by an experienced qualitative researcher external to the study was used to ensure dependability. All research-related activities were also documented for the purpose of confirmability. Transferability was also ensured through member checking by two nurses who were external to the study but had the same conditions as study participants. They approved the similarity of our findings with their own experiences.

## Results

Participants were sixteen nurses in the trauma, general, and cardiac surgery ICUs of two teaching hospitals in Isfahan, Iran. Most of them were female and aged 24–34 years. Their work experience ranged from one to twelve years (Table 1).

A total of 304 primary codes were generated during data analysis which were grouped into twelve subcategories and two main categories. The two main categories of the study were purposeful nursing care and humanistic care provision beyond duty (Table 2).

### Purposeful nursing care

A holistic nurse is a nurse who takes a holistic approach and considers all physical, psychological, social, and spiritual aspects of care. The four subcategories of this main category were physical care, psychological support, social support, and spiritual care.

### Physical care

Physical care was a priority for nursing care in ICU. Altered

**Table 1.** Participants' demographic characteristics

No.	Role in ICU	Age (y)	Gender	Degree	Work experience in ICU (y)
1	Nurse	31	Male	Bachelor's	6
2	Nurse	37	Female	Master's	8
3	Nurse	29	Male	Bachelor's	5
4	Nurse manager	40	Female	PhD	7
5	Nurse	26	Male	Master's	3
6	Nurse	25	Female	Bachelor's	2
7	Nurse manager	37	Female	Master's	8
8	Nurse manager	39	Female	PhD	5
9	Nurse	35	Female	Bachelor's	10
10	Nurse	36	Female	Bachelor's	8
11	Nurse	29	Female	Master's	5
12	Nurse	27	Male	Bachelor's	4
13	Nurse	33	Female	Bachelor's	7
14	Nurse	24	Male	Bachelor's	1
15	Nurse manager	43	Female	Bachelor's	12
16	Nurse	26	Male	Bachelor's	3

**Table 2.** Categories and subcategories of the study

Categories	Subcategories
Purposeful nursing care	Physical care
	Psychological support
	Social support
	Spiritual care
Humanistic care provision beyond duty	Continuous presence of nurse
	Communications
	Reciprocal interaction
	Empathetic understanding
	Compassionate behavior
	Patient support
	Participation in decision making
	Family-centered care

consciousness, unstable hemodynamic conditions, and the need for mechanical ventilation and specialized monitoring were among the most important reasons for careful attention to physical care. Most participants reported that they devoted most of their time to physical patient care.

*"At patient bedside, I always assess their conditions, including their level of consciousness, vital signs, ventilator setting, medications and intravenous solutions, need for position change, and function of drainage systems and catheters. Then, I perform airway suctioning and finally perform gavage. I perform the activities based on their priority"* (P. 4).

### Psychological support

Most participants emphasized the importance of psychological support for patients in ICU, particularly

conscious patients.

*"Nurses have the knowledge of caring and are responsible for patient care. Thus, they need to have a holistic approach to care. In other words, they need to consider patients as human beings and provide not only physical care, but also mental, emotional, and spiritual care"* (P. 7).

*"Hospitalized patients have high levels of stress and worries. For example, a conscious patient may sometimes be unable to have elimination in the unit due to the feelings of embarrassment and blame. Ineffective elimination can in turn cause some problems and prolong disease course and hospitalization"* (P. 2).

### Social support

Participants considered social support for patients in ICU as one of the main aspects of HC due to patients' limited access to their family members during ICU stay.

*"One of the common concerns of patients is the need to visit their family members and companions as well as to know about their work status outside hospital. These issues should be addressed. Whenever patients are worried and request, I contact their families and allow patients to talk to them. This really calms them. For patients with high levels of stress and worry, I make the necessary arrangement for patient visitation by family members. Attendance of the family members of patients, particularly conscious patients, reduces the stress of both patients and family members"* (P. 8).

### Spiritual care

Most participants referred to considering and fulfilling patients' spiritual needs as an important aspect of HC.

*"We had a Christian patient who had the Bible with himself. He asked me to give it from the locker to him. I gave it and even asked him to recite it for me and explain for me about its content. Moreover, we had a Muslim patient who liked to pray. At the praying time, I aligned his bed towards Mecca and provided him with the ability to comfortably pray"* (P. 14).

### Humanistic care provision beyond duty

HC provision beyond the assigned duty was the other main category of HC in the present study. The subcategories of this category were continuous presence of nurse, communication, reciprocal interaction, empathetic understanding, compassionate behavior, patient support, participation in decision making, and family-centered care.

### Continuous presence of nurse

Most participants highlighted the importance of nurses' presence at patient bedside, even unconscious patients, and considered it as an important component of HC with potential positive effects on patients' calmness and stress.

*"I mostly do evening and night shifts to be able to spend more time with patients. I greatly value nurse*

presence at patient bedside. It is also important for patients to see your continuous presence at their bedside. I write nursing reports at patient bedside and with patient companionship, whether they are conscious or unconscious” (P. 5).

### Communications

All participants admitted that communication with patients is a prerequisite to HC.

“Patients primarily need to know where they are. They need effective communication even if they are intubated. At patient bedside, I assess patients’ appearance, start my patient assessment, and talk to patients whether they are conscious or unconscious” (P. 6).

“Communication with patients is a priority for me and I talk to patients irrespective of their consciousness status. Of course, communication with unconscious patients is more difficult. Some individuals may not greatly value communication with a patient who has a Glasgow Coma Scale score of 3. However, I attempt to talk to such patients and provide all care services” (P. 13).

### Reciprocal interaction

Participants highlighted the importance of reciprocal interaction during HC provision, particularly to conscious patients.

“Conscious patients experience more stress and anxiety. Most of the times, talking to them and asking them to express their concerns reduce their stress. Most conscious patients have stress due to their disease and unawareness of their treatment. In these cases, I attempt to calm them through providing some explanations” (P. 9).

“I ask conscious patients to express their needs” (P. 11).

### Empathetic understanding

According to the participants, empathy is a very important component of HC provision to patients in ICU.

“Well, patients in ICU need nurses to fulfill even their most trivial needs. Most of the times, we use physical and chemical restraints for agitated patients. Restraint is very difficult for patients. I always say that we should put ourselves in patients’ shoes and imagine what we would need and what should be done for us if we were in their shoes. I really attempt to assess my patients with this view” (P. 12).

### Compassionate behavior

Participants also referred to compassion as another aspect of HC in ICU.

“In my opinion, patients in ICU, particularly conscious patients, need propitiation and kindness. Of course, I also attempt to treat unconscious patients as conscious patients. However, sometimes the puffy face and the terminal conditions of patients made it

difficult to treat them with compassion” (P. 4).

“Sometimes, we are affected by the difficult conditions and suffering of patients. In these situations, I attempt to more kindly treat them, more kindly talk to them, and show patience to them when they are bad tempered” (P. 10).

### Patient support

Support is a key component of nursing care so that nurses are considered a main source of support for patients. Our participants described patient support, protecting patient privacy, and protecting patients, particularly unconscious patients, against potential injuries during the process of care and treatment as components of HC.

“Unconscious patients have more care-related needs compared with conscious patients due to their complete dependence on care providers. Protecting patient privacy during care measures is among the responsibilities of nurses. Unconscious patients have no decision making and choice power and hence, nurses have critical role in advocating them and protecting them against treatment-related injuries” (P. 7).

“Patients in ICU need nurses’ support. In my opinion, little children and very old individuals specifically need support” (P. 16).

### Participation in decision making

The inclusion of patient-centered and humanistic ideas and perspectives in healthcare systems has improved patients’ status in the process of care and treatment so that patients can actively participate in care provision. Our participants also considered patients’ participation in decision making as a component of HC. They highlighted that patients’ participation in decision making along with their sense of equity in the process of care improve senses of respect, dignity, confidence, and security among them and their families. They noted that HC provision needs adequate educational and cultural infrastructures.

“Patient participation in decision making is among the ethical standards of care and patient rights. Patients and their family members experience high levels of stress due to their inadequate information about disease and treatment. Education in this area for healthcare providers and modification of attitudes and culture are necessary. Healthcare providers need to involve patients and their families in treatment. In my opinion, getting patients’ permission before care measures and talking to patients and their families about the process of treatment are associated with respect to them and their dignity and improve their sense of confidence and security” (P. 4).

### Family-centered care

Family-centered care not only helps prioritize patient needs, but also helps families support their patients. Most of our participants considered family support and family participation in the process of care as components of HC.

They noted unawareness of the family conditions as a main source of stress for patients in ICU and considered informing patients about their families as a component of HC and a factor with potential positive effects on patient recovery.

*“In my opinion, attention to patient family and companion is an aspect of HC. Companions’ needs are one of the most important concerns of patients in ICU and special attention in this area is needed”* (P. 8).

*“First-degree family members can have significant role in providing mental, emotional, and spiritual care to patients”* (P. 7).

*“Certainly, family members have close relationship with patients and their culture and belongingness are the same as the culture and belongingness of their patients. They like to participate in the process of care. I have seen that family members’ presence at patient bedside improves patients’ breathing. The presence of family members is more important for conscious patients. In my opinion, loneliness in ICU and witnessing individuals who do not communicate and just repeat a series of repetitive activities is very distressing for patients”* (P. 4).

## Discussion

The aim of this study was to explore nurses’ beliefs about HC provision to patients in ICU. Nurses’ beliefs about HC came into the two main categories of purposeful nursing care and humanistic care provision beyond duty.

Purposeful nursing care was the first main category of nurses’ beliefs about HC provision to patients in ICU. The subcategories of this category were physical care, psychological support, social support, and spiritual care, which are the same as the components of HC. In line with these findings, Florence Nightingale states that nurses should use their hands, hearts, and minds to create a healing environment for care provision to patients’ body, soul, and mind (18). Holism also holds that human being is more than the combination of his body, mind, and soul and considers human existence as the interrelationships of the body, mind, soul, and emotion. A study reported that patients in ICU not only need extensive physical care due to their critical conditions, but also need psychological care due to experiencing fear, anxiety, and anger as well as emotional, spiritual, and social changes (3). Spiritual care is a main aspect of HC (19). A study reported spiritual care as a multidimensional concept with dimensions such as respect, patient privacy, careful listening to patients, and helping them get aware of the course of their disease and considered spirituality as the essence of human existence with positive impact on recovery (8).

The findings of the present study revealed that nurses in ICU mostly focused on physical care provision to their patients. In line with this finding, a study in Iran reported that nurses may have inadequate knowledge and skills for HC due to nursing staff shortage, fatigue, managers’ greater interest in routine physical care, and limited

emphasis on HC in nursing education (20). Another study in Iran showed that nursing care in Iran mostly focuses on physical care and highlighted the need for more attention to the other aspects of care (21).

The second main category of the study was humanistic care provision beyond duty. Findings revealed that nurses in ICU attempted to have a holistic approach to care and to fulfill the different physical, mental, spiritual, and social needs of their patients. Continuous presence of nurse at patient bedside was one of the subcategories of this category. Participants referred to nurses’ continuous presence as an effective strategy to improve sense of security, reduce stress, and facilitate patient recovery. A study referred to nurse presence as a therapeutic relationship during reciprocal interactions which leads to attention to patients and all their needs (22).

Communication was another subcategory of the second main category. Participants reported communication, even with patients with altered consciousness, as a very important prerequisite to HC provision. A previous study in Iran showed that nurses played active role in establishing communication with patients and always attempted to improve their relationship with patients and noted that nurses’ attempt to communicate with patients and fulfill their needs can give patients sense of trust. Nurses in that study introduced communication as the essence of nursing care (23). Another study reported that communication with the holistic approach is the art of sharing real and emotional information. It highlighted that this communication begins with non-verbal communication (such as warm reception, eye contact, and open face during contacts), continues with a desire to listen to patients’ experiences, thoughts, and feelings, and is associated with positive effects on patients’ physical health and patients’ and nurses’ experiences of care (24).

Another subcategory of the humanistic care provision beyond duty category was reciprocal interaction. Study participants reported reciprocal interaction together with giving feedback to patients, particularly conscious patients, as an important component of HC which gives patients sense of value and reduces their stress. A review study also indicated the importance of nurse-patient communication and interaction in ICU (25).

Empathetic understanding and compassionate behaviors were two other subcategories of the humanistic care provision beyond duty category in the present study. Participants reported that they attempted to identify the different needs of patients in ICU, particularly those under mechanical ventilation, through strategies such as putting themselves in patients’ shoes. They described empathy and compassion as kind behaviors, consolation, caress, and patience towards patients’ restlessness and bad temper. A study showed that nurses in Iran considered compassion as a sense of value and affection for others and considered attention to patients, answering their questions, smiling, touching, and caressing as methods to show them affection and empathy at the time of

their suffering (26). A systematic review also revealed compassion as conscious care for others' problems, sensitivity to pain, and staying close to others (27).

Patient support was also an important aspect of HC in the present study. Participants reported that nurses are a source of support and advocacy for patients to maintain their privacy and prevent potential injuries to patients in ICU, especially to patients with altered consciousness, children, and elder adults. Nurses in another study also considered proper support as a philosophy of nursing and reported helping patients to access the necessary care services, quality assurance, and protecting patient rights as examples of patient support (28). A study in Iran also revealed informing patients, respecting and honoring their human dignity and privacy, and protecting them as the components of patient support (29).

Patients' participation in decision making was another component of HC in the present study. Findings revealed unawareness and limited information about disease and treatment as major sources of stress for patients and families and highlighted involvement of patients in clinical decision making as respect for their human dignity and a factor in ensuring patient safety and trust. A study defined patients' participation in decision making as interactive decision making, collaboration between nurses and patients, exchange of information, provision of respect, and obtaining patient permission. It also noted that patients' participation in decision making can be associated with patients' greater collaboration with nurses, their greater trust in nurses, feelings of enjoyment and worth, better coping with disease, positive psychological effects, protection of patient dignity, greater patient satisfaction, and lower levels of stress for patients as well as greater job satisfaction and lower stress for nurses (30). Another study also showed that patients' participation improves patient and nurse satisfaction and professional interactions (31).

We also found family-centered care as a component of HC. Participants reported that participation of family members in care provision is effective in reducing stress among patients and families and improving patients' clinical status. A review study showed that involvement of family members in care provision to patients in ICU can reduce patients' and families' stress, empowers family members, and has other benefits for patients and family members (32). Nurses in another study also valued the role of family caregivers in care provision and believed that family members' presence provides senses of security and trust for families and patients (33).

## Conclusion

This qualitative study shows that nurses attempt to provide HC and go beyond their assigned duties in HC provision. Moreover, this study reveals more aspects of the concept HC from the perspectives of nurses in ICU. The findings of the present study can be used to conduct more studies into HC provision in ICU and other clinical

## What does this paper contribute to the wider global clinical community?

- HC provision to patients in ICU encompasses many different aspects from physical care, psychological support, social support, and spiritual care to continuous presence of nurse, communication, reciprocal interaction, empathetic understanding, compassionate behavior, patient support, participation in decision making, and family-centered care.
- Nurses in ICU attempt to provide HC beyond their assigned duties.

settings. Future studies are recommended to assess the different aspects of HC from the perspectives of nurses and physicians in ICU.

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## Conflict of Interest

None of the authors declare any conflict of interest.

## Ethical Approval

The Ethics Committee of Isfahan University of Medical Sciences, Isfahan, Iran, approved this study (code: IR.MUI.RESEARCH.REC.1398.296). All participants were informed about the study aim and voluntariness of participation in and withdrawal from the study. Informed consent was obtained from all participants.

## References

1. Gaeni M, Ashghali-Farahani M, Mohammadi N, Seyedfatemi N, Abbasi M. To restore the stability: family experiences of patients in intensive care unit. *J Qual Res Health Sci*. 2020;7(1):103-18. [Persian].
2. Berntzen H, Bjørk IT, Storsveen AM, Wøien H. "Please mind the gap": a secondary analysis of discomfort and comfort in intensive care. *J Clin Nurs*. 2020;29(13-14):2441-54. doi: 10.1111/jocn.15260.
3. Alasad JA, Abu Tabar N, Ahmad MM. Patients' experience of being in intensive care units. *J Crit Care*. 2015;30(4):859.e7-859.e11. doi: 10.1016/j.jcrc.2015.03.021.
4. Holm A, Dreyer P. Nurse-patient communication within the context of non-sedated mechanical ventilation: a hermeneutic-phenomenological study. *Nurs Crit Care*. 2018;23(2):88-94. doi: 10.1111/nicc.12297.
5. Cohen BS, Boni R. Holistic Nursing Simulation: A Concept Analysis. *J Holist Nurs*. 2018;36(1):68-78. doi: 10.1177/0898010116678325.
6. American Holistic Nurses Association. About Us. Available from: <http://www.ahna.org/About-Us/What-We-Do>. Accessed January 8, 2017.
7. Ghorbani F, Salsali M. Concept of holistic in nursing: a review article. *J Educ Ethics Nurs*. 2018;7(3-4):23-30. doi: 10.52547/ethicnurs.7.3.4.23. [Persian].
8. Zamanzadeh V, Jaseemi M, Valizadeh L, Keogh B, Taleghani F. Effective factors in providing holistic care: a qualitative study. *Indian J Palliat Care*. 2015;21(2):214-24. doi: 10.4103/0973-1075.156506.
9. Albaqawi HM, Butcon VR, Molina RR. Awareness of holistic care practices by intensive care nurses in north-western Saudi

- Arabia. *Saudi Med J*. 2017;38(8):826-31. doi: [10.15537/smj.2017.8.20056](https://doi.org/10.15537/smj.2017.8.20056).
10. Daaleman TP, Usher BM, Williams SW, Rawlings J, Hanson LC. An exploratory study of spiritual care at the end of life. *Ann Fam Med*. 2008;6(5):406-11. doi: [10.1370/afm.883](https://doi.org/10.1370/afm.883).
  11. Selimen D, Andsoy II. The importance of a holistic approach during the perioperative period. *AORN J*. 2011;93(4):482-90. doi: [10.1016/j.aorn.2010.09.029](https://doi.org/10.1016/j.aorn.2010.09.029).
  12. Adib-Hajbaghery M, Saeadnejad Z. Barriers to provide patients admitted to hospitals in Kashan with spiritual care: nurses' viewpoints. *J Med Ethics*. 2016;10(37):49-59. [Persian].
  13. Tayebi Z, Dehghan Nayeri N, Barimnejad L, Nabi Amjad R. Exploring the process of patient visiting in adult intensive care units. *Alborz Univ Med J*. 2020;9(2):143-53. doi: [10.29252/aums.9.2.143](https://doi.org/10.29252/aums.9.2.143). [Persian].
  14. Kondracki NL, Wellman NS, Amundson DR. Content analysis: review of methods and their applications in nutrition education. *J Nutr Educ Behav*. 2002;34(4):224-30. doi: [10.1016/s1499-4046\(06\)60097-3](https://doi.org/10.1016/s1499-4046(06)60097-3).
  15. Graneheim UH, Lindgren BM, Lundman B. Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Educ Today*. 2017;56:29-34. doi: [10.1016/j.nedt.2017.06.002](https://doi.org/10.1016/j.nedt.2017.06.002).
  16. Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet*. 2001;358(9280):483-8. doi: [10.1016/s0140-6736\(01\)05627-6](https://doi.org/10.1016/s0140-6736(01)05627-6).
  17. Poortaghi S, Raiesifar A, Bozorgzad P, Raiesifar Z, Teymuri E, Saraee S. Reflexivity and its application in qualitative researches: a narrative review. *Iran J Nurs Res*. 2019;13(5):46-51. [Persian].
  18. Norman V, Rossillo K, Skelton K. Creating healing environments through the theory of caring. *AORN J*. 2016;104(5):401-9. doi: [10.1016/j.aorn.2016.09.006](https://doi.org/10.1016/j.aorn.2016.09.006).
  19. Batstone E, Bailey C, Hallett N. Spiritual care provision to end-of-life patients: a systematic literature review. *J Clin Nurs*. 2020;29(19-20):3609-24. doi: [10.1111/jocn.15411](https://doi.org/10.1111/jocn.15411).
  20. Hajinezhad MS, Rafii F, Jafarjalal E, Haghani H. Relationship between nurse caring behaviors from patients' perspectives & their satisfaction. *Iran Journal of Nursing*. 2007;20(49):73-83. [Persian].
  21. Peyrovi H, Bahadori A, Ashghali-Farahani M, Haghani H. Comparison of in-patients' satisfaction with different domains of nursing care. *Quarterly Journal of Nursing Management*. 2013;2(1):59-66. [Persian].
  22. Mohammadipour F, Atashzadeh-Shoorideh F, Parvizy S, Hosseini M. Concept development of "Nursing presence": application of Schwartz-Barcott and Kim's hybrid model. *Asian Nurs Res (Korean Soc Nurs Sci)*. 2017;11(1):19-29. doi: [10.1016/j.anr.2017.01.004](https://doi.org/10.1016/j.anr.2017.01.004).
  23. Fakhr-Movahedi A, Negarandeh R, Salsali M. Exploring nurse-patient communication strategies. *Hayat*. 2012;18(4):28-46. [Persian].
  24. Klagsbrun J. Listening and focusing: holistic health care tools for nurses. *Nurs Clin North Am*. 2001;36(1):115-30.
  25. Kwame A, Petrucka PM. Communication in nurse-patient interaction in healthcare settings in sub-Saharan Africa: a scoping review. *Int J Afr Nurs Sci*. 2020;12:100198. doi: [10.1016/j.ijans.2020.100198](https://doi.org/10.1016/j.ijans.2020.100198).
  26. Babaei S, Taleghani F. Compassionate care challenges and barriers in clinical nurses: a qualitative study. *Iran J Nurs Midwifery Res*. 2019;24(3):213-9. doi: [10.4103/ijnmr.IJNMR\\_100\\_18](https://doi.org/10.4103/ijnmr.IJNMR_100_18).
  27. Sinclair S, Norris JM, McConnell SJ, Chochinov HM, Hack TF, Hagen NA, et al. Compassion: a scoping review of the healthcare literature. *BMC Palliat Care*. 2016;15:6. doi: [10.1186/s12904-016-0080-0](https://doi.org/10.1186/s12904-016-0080-0).
  28. Davoodvand S, Abbaszadeh A, Ahmadi F. Patient advocacy from the clinical nurses' viewpoint: a qualitative study. *J Med Ethics Hist Med*. 2016;9:5.
  29. Negarandeh R, Oskouie SF, Ahmadi F, Nikravesh M. Patient advocacy barriers and facilitators in nurses' experiences. *Razi J Med Sci*. 2005;12(47):175-86. [Persian].
  30. Orujlu S, Zamanzadeh V, Valizadeh L. Nurses' experiences of patient participation in nursing care and its related factors: a qualitative content analysis. *Hayat*. 2020;25(4):401-14. [Persian].
  31. Ding B, Liu W, Tsai SB, Gu D, Bian F, Shao X. Effect of patient participation on nurse and patient outcomes in inpatient healthcare. *Int J Environ Res Public Health*. 2019;16(8):1344. doi: [10.3390/ijerph16081344](https://doi.org/10.3390/ijerph16081344).
  32. Al Mutair A, Al Shaer A, Al Ghamdi F, Al Ghamdi A. The experiences of Muslim family members of critically ill patients during end-of-life care in Saudi Arabia: a qualitative phenomenological study. *Clin Nurs Res*. 2020;29(6):375-81. doi: [10.1177/1054773818788969](https://doi.org/10.1177/1054773818788969).
  33. Fateel EE, O'Neill CS. Family members' involvement in the care of critically ill patients in two intensive care units in an acute hospital in Bahrain: the experiences and perspectives of family members' and nurses'-a qualitative study. *Clin Nurs Stud*. 2016;4(1):57-69. doi: [10.5430/cns.v4n1p57](https://doi.org/10.5430/cns.v4n1p57).

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