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Addressing spirituality during critical illness: A review of current literature☆

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ABSTRACT

Objectives: The purpose of this review is to provide an overview of research on spirituality and religiosity in the intensive care setting that has been published since the *2004–2005 American College of Critical Care Medicine (ACCM) Clinical Practice Guidelines for the Support of Family in the Patient-Centered Intensive Care Unit* with an emphasis on its application beyond palliative and end-of-life care.
Materials and methods: ACCM 2004–2005 guidelines emphasized the importance of spiritual and religious support in the form of four specific recommendations: [1] assessment and incorporation of spiritual needs in ICU care plan; [2] spiritual care training for doctors and nurses; [3] physician review of interdisciplinary spiritual need assessments; and [4] honoring the requests of patients to pray with them. We reviewed 26 studies published from 2006 to 2016 and identified whether studies strengthened the grade of these recommendations. We further categorized findings of these studies to understand the roles of spirituality and religiosity in surrogate perceptions and decision-making and patient and family experience.
Conclusions: Spiritual care has an essential role in the treatment of critically ill patients and families. Current literature offers few insights to support clinicians in navigating this often-challenging aspect of patient care and more research is needed.

Contents

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1. Introduction

In 2004, ACCM created a task force to develop *Clinical Practice Guidelines for the Support of Family in the Patient-Centered ICU*. The importance of spiritual and religious support was emphasized in the form of four specific recommendations: 1) assessment and incorporation of spiritual needs in the ICU care plan; 2) spiritual care training for doctors and nurses; 3) physician review of spiritual needs from interdisciplinary assessments; and 4) honoring the requests of patients to pray with them [1].

Physicians, nurses, social workers and hospital chaplains have increasingly acknowledged the roles of religion and spirituality in patients' lives. Various groups have recommended policies that address spiritual and religious support. The International Council of Nurses in its "Vision for the Future of Nursing," specifically included spiritual needs in the definition of compassionate and ethical care [2]. The North American Nursing Diagnosis Association (NANDA) created two specific diagnoses related to spiritual care: spiritual distress and readiness for enhanced spiritual well-being [3]. In 1995, social workers' education and client diversity programs also incorporated religion and spirituality. The National Association of Social Workers includes spiritual support in their *Standards for Cultural Competence in Social Work Practice* [4]. Since the 1940s, hospital chaplaincy has created a "sacred space" for people of all faiths and cultural beliefs to help find meaning, hope, and connection in stressful moments and draw upon their own sources of inner strength.

In addition to the bedside team, Centers for Medicare and Medicaid (CMS - the largest healthcare payer in the United States) and the Joint Commission (the largest accrediting body) have both recognized the importance of spiritual and religious support. CMS requires a spiritual care assessment for all patients admitted into hospice or palliative care in order to receive reimbursement [5]. The Joint Commission has written extensively on how essential spiritual and religious care are for effective communication, cultural competence, and patient and family centered care [6].

There continues to be discordance between recommendations and clinical practice especially in the intensive care setting. The 2004–2005 ACCM Task Force recommendations for spiritual/religious support were based on research from outside the ICU and explicitly indicated the need for ICU-specific studies [1]. The purpose of this review is to explore emerging research on spirituality and religiosity in the intensive care setting that has been published since the 2004–2005 Task Force report, with an emphasis on its application beyond palliative and end-of-life care.

2. Methods

Articles were retrieved from PubMed and PsycInfo. MESH terms were: religion, critical care, critical care nursing, critical care outcome, critical illness. Search terms for Pubmed were: 'spiritual*', 'religion*', 'faith', 'critical', 'intensive', 'aggressive', 'care', 'ill', 'illness'. Search terms for PsycInfo were: 'spiritual', 'religion', 'critical care' and 'intensive care'. Our search was limited to articles published in core clinical journals from January 2006 to June 2016. Notably, while the guidelines were published in 2007, our search was done based on the end of date for data collection as stated in the article, which was the end of 2005. In addition, any article with the direct aim of palliative and end-of-life care was excluded. Inclusion criteria were: intensive care/critical care setting (adult, pediatric, & neonatal intensive care), patient focused, English language, and conducted in North America. The interpretation of "patient-focused" as applied here was based on the Institute of Medicine definition: *"Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."* [7] Exclusion criteria were: expert opinions, policy statements, articles focused on palliative care or end-of-life care only, conducted outside of North America, unavailable full texts, and non-English texts.

The articles meeting criteria were compared to their relevance to the four recommendations of the ACCM clinical practice guidelines (Table 1), and then classified as representing a distinct topic or not. The *Clinical Practice Guidelines for the Support on the Family in the Patient-Centered ICU* was developed through a multidisciplinary task force of experts in critical care from the ACCM and the Society of Critical Care Medicine (SCCM). The guidelines addressed ten different aspects of care in the ICU. This review will focus on recommendations made under the aspect of spiritual/religious support. Most of the research was given a Cochrane grade of C or D (case series, expert opinion, or surveys) [1]. Articles that addressed a specific recommendation with clinical research were classified as "supporting" articles. Articles that pertained to critical care, such as surrogates' spirituality-based decision making but did not address ACCM guidelines directly were deemed "topical" (Table 2). We note that direct pertinence to a recommendation does not bear on the essential quality of the evidence, only the context of the study.

Alongside the review of articles that met our inclusion criteria and pertinence to ACCM guidelines, we conducted a qualitative analysis to determine emerging themes. This involved labeling each study with the relevant ACCM guidelines and summarizing the additional topics addressed by the study. Then, the additional topics were reviewed to evaluate whether any common topics emerged. Any common topic with more than three pertaining articles was considered an emerging theme.

It is also necessary to note that definitions for religiosity and spirituality have been subjects of diverse opinions for many years [8]. Although most recent literature defines them as separate entities, the majority of articles reviewed used these terms interchangeably. For the purposes of

Table 1
ACCM recommendations on spiritual/religious support in the ICU.

1	Spiritual needs of the patient are assessed by the healthcare team, and findings that affect health and healing incorporated into the plan of care.
2	Nurses and doctors receive training in awareness of spiritual and religious issues so that they may properly assess patients and make use of findings in the plan of care written by social workers and chaplains.
3	Physicians will review reports of ancillary team members such as chaplains, social workers, and nurses to integrate their perspectives into patient care. Chaplains and social workers are trained to explore spiritual issues and can provide intensivists with valuable insights into the patient's condition.
4	If a patient requests that a healthcare provider pray with him or her, and the healthcare worker agrees to and feels comfortable with it, the request is honored and considered to be part of the spectrum of holistic intensive care.