Original Article

"The Patient Is Dying, Please Call the Chaplain": The Activities of Chaplains in One Medical Center's Intensive Care Units

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Abstract

Context. Patients and families commonly experience spiritual stress during an intensive care unit (ICU) admission. Although most patients report that they want spiritual support, little is known about how these issues are addressed by hospital chaplains.

Objectives. To describe the prevalence, timing, and nature of hospital chaplain encounters in ICUs.

Methods. This was a retrospective cross-sectional study of adult ICUs at an academic medical center. Measures included days from ICU admission to initial chaplain visit, days from chaplain visit to ICU death or discharge, hospital and ICU lengths of stay, severity of illness at ICU admission and chaplain visit, and chart documentation of chaplain communication with the ICU team.

Results. Of a total of 4169 ICU admissions over six months, 248 (5.9%) patients were seen by chaplains. Of the 246 patients who died in an ICU, 197 (80%) were seen by a chaplain. There was a median of two days from ICU admission to chaplain encounter and a median of one day from chaplain encounter to ICU discharge or death. Chaplains communicated with nurses after 141 encounters (56.9%) but with physicians after only 14 encounters (5.6%); there was no documented communication in 55 encounters (22%).

Conclusion. In the ICUs at this tertiary medical center, chaplain visits are uncommon and generally occur just before death among ICU patients. Communication between chaplains and physicians is rare. Chaplaincy service is primarily reserved for dying patients and their family members rather than providing proactive spiritual support. These observations highlight the need to better understand challenges and barriers to optimal chaplain involvement in ICU patient care. J Pain Symptom Manage 2015;50:501–506.

Key Words

Intensive care, critical care, chaplain, spiritual care, death, religion

Introduction

Admission to the intensive care unit (ICU) is a stressful and vulnerable experience for both patients and families, often eliciting spiritual questions and concerns.[1] One in five deaths in the U.S. will occur in the ICU or shortly after discharge from the ICU, and most of these deaths will occur from withdrawing life support or incurable illnesses.[2] During this time, patients and families look not only to medical interventions for healing but also many desire emotional and spiritual healing.[3]

Most Americans consider religion important in daily life.[4] A study in cancer outpatients showed that patients with positive religious coping tend to have higher rates of ICU death, more aggressive care at the end of life, less hospice use, and greater health care costs at the end of life, signifying that religion and spirituality may be important in end-of-life decision making.[5,6] Also, when spiritual needs are not met by the health care team, patients tend to rate care more poorly.[7,8] In contrast, when spiritual needs are met by the health care team, patients have less aggressive care, more

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hospice use, lower rates of ICU death, and lower health care costs at the end of life.[9,10] There also have been possible correlations specifically between chaplain visits and hospice use.[11] Addressing spiritual issues of patients is now required by the National Palliative Care guidelines and the Joint Commission.[12,13] In addition, a task force of experts in critical care medicine, in a consensus statement on clinical practices, expressed the importance of addressing spiritual needs of patients and families in the ICU.[14] However, few patient care teams explicitly address the spiritual needs of patients and families.[4,15]

Physicians typically feel unprepared to elicit patients' spiritual beliefs, include religion and spirituality in decision making, or address the spiritual needs of patients and families.[16,17] Hospital chaplains are considered the spiritual professionals in the inpatient setting. Although the literature regarding chaplain involvement in the hospital setting is growing, in Australia and New Zealand, chaplains have been shown to be important in various clinical contexts, including pain control, bioethics, and treatment decisions.[18–20] Studies in discharged general medical inpatients have found that patients would welcome chaplain visits, but these visits tend to be infrequent.[21] However, there is still limited research in understanding the role of chaplains specifically in the ICU—a potentially important opportunity to help address patients' and families' spiritual crises.

To begin to identify targets for improving spiritual care for patients and families in the ICU, we performed a six-month retrospective study in a single large academic medical center. Our primary aim in this study was to describe the patient population in the ICUs at Duke University Hospital who receive chaplain visitation, as well as the timing and content of these visits in relationship to ICU admission and discharge or death. Our secondary aim was to understand the referral and communication patterns between hospital chaplains and the primary ICU team. Based on our clinical experience, we hypothesized that chaplain visits in the ICU are primarily reserved for the families of actively dying patients and that communication between hospital chaplains and ICU physicians is limited. Our overarching goal is to understand how spiritual care is currently being provided and to identify ways to improve spiritual care for patients and families in the ICU.

Methods

Design

We performed a cross-sectional retrospective chart review over a six-month period, coinciding with the implementation of a new electronic health record (EHR) system. We identified the study population using queries of the EHR. First, we identified all adult patients aged 18 years and older who were admitted to one of five adult ICUs at Duke University Hospital between June 24, 2013 and December 24, 2013. These ICUs included the medical intensive care unit (MICU), cardiac care unit, neurointensive care unit, cardiothoracic intensive care unit (CTICU), and surgical intensive care unit. The final study population was then captured by identifying all patients with at least one encounter note signed by a chaplain, chaplain resident, or chaplain intern during the ICU admission that immediately preceded hospital discharge or death. At Duke University Hospital, there are four chaplain residents who train for one year, staffing the five adult ICUs during the day, whereas chaplain interns and residents take call overnight. Any member of the ICU team may request a chaplain visit, or chaplains may self-initiate visits. Although a question regarding spiritual needs is part of the initial nursing admission assessment, there are no other clear systematic triggers or protocols for chaplain visits during an ICU stay. Among non-ICU patients, the only clear trigger for a chaplain visit is when a code blue for cardiorespiratory arrest is called. All chaplains at Duke University Hospital are trained in electronic documentation of all patient encounters, including when patients or families are unavailable at the time of visitation. The subject of documentation includes ministry interventions performed, from whom the consult was received and with whom the patient encounter was discussed.

Study Measures

We recorded age, gender, race, religion, and ICU location of all patients from EHR queries. Similarly, primary ICU admission diagnosis, ICU lengths of stay (LOS), ventilator days (if applicable), and hospital LOS were collected by review of the medical record. Severity of illness was calculated both at the time of index ICU admission and the time of first chaplain visit using the sequential organ failure assessment (SOFA) score. The SOFA score takes into account the partial pressure of arterial oxygen to fraction of inspired oxygen ratio (PaO_2/FiO_2), mean arterial pressure/vasopressor use, Glasgow Coma Scale, bilirubin, platelets, and creatinine/urine output to create a composite score of organ dysfunction, with one study showing an initial/highest SOFA of greater than 11 predicting up to 80% mortality.[22] For missing values, normal values were substituted. Bilirubin and Glasgow Coma Scale were most frequently missing, in which case SOFA may be underestimated. Circumstance of death (cardiac arrest with active attempt at resuscitation or withdrawal of life support) or discharge disposition was recorded. The date of the first chaplain note was recorded, and from this, we determined the number of days from ICU admission