

Spiritual Care in the Intensive Care Unit: A Narrative Review

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Abstract

Spiritual care is an important component of high-quality health care, especially for critically ill patients and their families. Despite evidence of benefits from spiritual care, physicians and other health-care providers commonly fail to assess and address their patients' spiritual care needs in the intensive care unit (ICU). In addition, it is common that spiritual care resources that can improve both patient outcomes and family member experiences are underutilized. In this review, we provide an overview of spiritual care and its role in the ICU. We review evidence demonstrating the benefits of, and persistent unmet needs for, spiritual care services, as well as the current state of spiritual care delivery in the ICU setting. Furthermore, we outline tools and strategies intensivists and other critical care medicine health-care professionals can employ to support the spiritual well-being of patients and families, with a special focus on chaplaincy services.

Keywords

intensive care unit (ICU), spiritual care, end of life, death and dying, critical care, chaplaincy

Introduction

The intensive care unit (ICU) has been described as lonely, mechanized, and dehumanizing.¹ It is a care setting where patients and their family members commonly experience fear and often contemplate the possibility of death.²⁻⁵ These experiences are often accompanied by profound emotional distress.⁶ Traditional medical therapy that aims primarily to treat the patient's underlying disease may be inadequate in addressing this distress. Indeed, patients and family members who experience critical illness often turn to spirituality or religion for support.⁷

There is a growing body of evidence that attending to the spiritual needs of patients and their families can improve outcomes including the quality of life, and several guidelines suggest spiritual care should be a part of comprehensive health delivery.^{6,8} However, in practice, spiritual care is often overlooked in the management of critically ill patients.

In this review, we define and describe spiritual care, highlight the benefits of spiritual care in the ICU, and outline the role of intensivists in supporting and facilitating its delivery. We recommend communication among multidisciplinary ICU medical team members to create a spiritually supportive atmosphere while serving the patient and family. Specifically, we encourage intensivists to utilize available hospital resources, such as chaplains, and take actions that promote spiritual and emotional understanding during patient interactions and family discussions.

Spiritual Care: Overview of Aims and Practice

Spirituality is a human characteristic that refers to the way individuals seek and express meaning and purpose and is often tied with the feeling of connectedness to the moment, self, others, nature, the significant, or the sacred.⁹⁻¹² Spirituality encompasses, but is not limited to, religion, which is defined as an established system of symbols, beliefs, rituals, and texts shared by a community of faith.¹³ In turn, spiritual care seeks to attend to an individual's spiritual or religious needs as he or she copes with illness, loss, grief, suffering, or pain.¹⁴

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Table 1. Overview of Spiritual Care.

Categories of Spiritual Care Practices ^a	Examples of Specific Interventions
Spirituality: The way individuals seek an express meaning and purpose	
Spiritual Care: Attention given to spiritual needs that arise with illness, loss, grief, or pain	
Religious	<ul style="list-style-type: none"> – Prayer – Distribution and discussion of religious materials – Encouragement of religious development – Discussion of patients' relationship to God – Religious witnessing
Spiritual	<ul style="list-style-type: none"> – Facilitation of finding meaning or purpose – Enabling existential empowerment – Guiding spiritual development – Providing end-of-life support
Counseling	<ul style="list-style-type: none"> – Establishment of rapport – Encouragement of (self) reflection – Encouragement of expression – Enabling hope – Enabling emotion – Negotiating internal/external conflict – Facilitation of closure
Emotional	<ul style="list-style-type: none"> – Communicating empathy – Providing comfort – Consoling patients – Demonstrating care and concern – Providing emotional support
Advocacy	<ul style="list-style-type: none"> – Cultural brokering – Communication of patient concerns/needs – Referral of patients to chaplains or clergy

^aCategories adapted from Hummel et al.¹⁵

Because of the breadth of human experience and belief, the practice of delivering spiritual care is likewise broad and expansive. In their exploratory review of the literature, Hummel et al describe 5 categories of spiritual care interventions: religious, spiritual, counseling, emotional, and advocacy (Table 1).¹⁵ Religious interventions include activities that are commonly associated with pastoral care such as praying with patients, providing and discussing/reading religious materials to patients, religious witnessing, and encouraging religious development. Spiritual interventions focus on facilitating finding meaning or purpose, helping patients prepare for the end of life/death, enabling existential empowerment, and providing spiritual resources. Counseling interventions involve establishing rapport, facilitating communication, encouraging reflection, and enabling hope. Emotional activities include communicating empathy, providing comfort, demonstrating concern, and

providing emotional support to patients. Advocacy describes cultural brokering, communicating patient concerns to others, and facilitating referrals to other chaplains or clergy. Spiritual care also comprises presence, respect, communication, and adjunctive therapies, such as art therapy and therapeutic touch. Although chaplains may specialize in these practices, any member of the health-care team can provide spiritual care by being attentive and listening to patients' feelings, taking appropriate spiritual histories, and supporting spiritual practices.¹⁶

Perceptions of Spiritual Care Need

There is a growing body of evidence that patients experience significant spiritual stress when confronted with advanced illness. In this setting, patients' spiritual needs may include, but are not limited to, coping with loss of roles, purpose and self-identity, feeling safe, building relationships, finishing business, forgiveness and reconciliation, letting go and acceptance, life review, and involvement and control.^{4,5,17-19} In a study of 542 hospitalized patients, Koenig found 88% of patients considered spiritual and religious beliefs to be important to them and 67% felt that they were important in coping with illness.²⁰ Several other studies have examined spirituality among patients with advanced cancer and have found that between 73% and 85% of patients describe having at least 1 spiritual need.²¹⁻²³ These needs included overcoming fears, finding hope, finding meaning, seeking closer connection, and seeking forgiveness.

Patients often want these spiritual needs addressed by their physicians. Ehman and colleagues found that 51% of their study participants from an outpatient pulmonary practice reported they were religious; moreover, 45% responded that if they became gravely ill, their medical decisions would be affected by their spiritual or religious beliefs.²⁴ Other groups have found 70% to 77% of patients in a primary care setting would want spiritual discussions with their physicians if facing life-threatening illness. Many of these same patients felt that these discussions could improve medical decision-making.^{25,26} Similar findings have been reported in populations of terminally ill patients with cancer and recently hospitalized patients.²⁷⁻²⁹

Advanced illness can also spur spiritual discord in caregivers and family members. Delgado et al reported 58% of caregivers of patients with advanced cancer experienced spiritual pain or suffering.³⁰ Another study found similar spiritual needs between patients with cancer and family caregivers. "Being positive, loving others, finding meaning, and relating to God" were the most important spiritual needs.^{31(p729)} Chang et al reported end-of-life veterans and their families had many spiritual needs, such as the desire to better comprehend traumatic events during their military experience.³²

There are fewer published reports addressing spiritual needs of patients and families in the critical care setting compared with other patient care settings. However, critically ill patients and family members commonly feel a need for spiritual care. For instance, in a qualitative study, Swinton et al conducted interviews of 76 family members and 150 clinicians reflecting on the care of 70 dying patients in the ICU. They concluded

that the vast majority of family members, as well as health-care staff, felt that dying was a spiritual event and that spirituality was integral to the patients' narrative.¹¹ Moreover, in their qualitative study of adult ICU patients, Kisorio and Langley found that the majority of family members valued religion and prayers as a form of hope and encouragement.³³ Similarly, in their analysis of spirituality and goals-of-care discussions in the ICU, Ernecoff et al reported that 77% of patient surrogates endorsed spirituality or religiosity and were often the first to broach the topic.³⁴ In a survey of parents of pediatric patients in the ICU, 48% desired their physician to enquire about their spiritual or religious beliefs and approximately two-third indicated they would feel comforted to know their child's physician prayed for their child.³⁵

Spiritual Care Needs of Health-Care Workers

The practice of medicine in general, and critical care medicine in particular, is demanding and stressful. Rates of burnout, a condition characterized by emotional exhaustion, depersonalization, and low sense of accomplishment, are higher in health-care workers than the general population. In their national survey of US physicians of all specialties, Shanafelt et al found that 37.9% of physicians reported burnout compared to 27.8% of the general population.³⁶ In the ICU, exposure to frequent situations involving death and dying may lead to increased spiritual conflict and further contribute to burnout.³⁷ Indeed, several studies have highlighted high burnout rates, ranging between 23% and 46%, among physicians and nurses working in the ICU.³⁸⁻⁴¹ These rates were often positively correlated with poor satisfaction with the end-of-life care delivery.^{38,41}

There has been some evidence that spirituality could be protective against burnout in health-care workers. In their 2 survey-based studies of internal medicine housestaff, Doolittle et al found that high scores on the Hatch Spiritual Involvement and Beliefs Scale were correlated with lower self-identified burnout.^{42,43} Although data specifically pertaining to the ICU are scarce, Meltzer and Huckabay reported that religiosity was protective against burnout in critical care nurses.⁴⁴ As such, tending to health-care workers' spiritual health and spiritual needs may be important in preventing emotional exhaustion in the ICU. Although more research is certainly needed into this topic, it is clear that health-care professionals' spiritual needs should not be ignored.

Benefits of Spiritual Care

Meeting the spiritual needs of patients with advanced illness has been associated with several benefits. One of these is the perception of improved quality of care. In a large qualitative study, veteran patients described spirituality and spiritual care as an aid to healing and as a stabilizing force that reduced anxiety and provided hope.⁴⁵ Moreover, in their study of 369 oncology patients, Astrow et al found that patients who felt their spiritual needs were addressed by their care team reported significantly higher satisfaction and quality of care scores.²² The

exploration of patient spiritual concerns by health professionals has been associated with greater satisfaction and improved quality of life.^{17,46} In their literature review of inpatient-based studies, Clark et al reported evidence that the degree to which hospital staff addresses emotional and spiritual needs is strongly linked to overall patient satisfaction.⁴⁷ Delivery of spiritual care also improves family perception of care. In a study of dying patients and long-term care facilities, family members reported better overall care scores if spiritual care was delivered (3.59 vs 3.25 [on a scale of 1-4; 4 being very good], $P = .002$).⁴⁸

In addition, providing spiritual care has been shown to have tangible effects on outcomes. Enrollment in hospice and palliative care services at the end of life increases the quality of life of patients.⁴⁹⁻⁵² Several studies suggest that those patients with advanced disease who receive spiritual counseling utilize hospice services to a higher degree than those who do not. For instance, hospitals with chaplaincy services are associated with significantly lower rates of hospital ICU deaths and higher rates of hospice enrollment.⁵³ Similarly, an investigation focused on a study population of terminally ill patients found spiritual support of patients by the medical team was associated with greater hospice utilization.⁵⁴ For the highly religious, there was an association between spiritual support and less aggressive care at the end of life as well.

Johnson et al documented the spiritual and religious activities initiated by spiritual care providers (SCPs) with family members of ICU patients and assessed family satisfaction with the spiritual care one month after patient death.¹⁰ Based on the responses, family activities with SCPs were associated with greater family satisfaction. In particular, discussions, preparations for family conferences, and the total number of activities were associated with increased family satisfaction regarding ICU decision-making. Wall et al observed that if a pastor or spiritual advisor was involved within 24 hours of patient death, family members were more satisfied with spiritual care.¹² They also found that spiritual care satisfaction is strongly associated with total ICU experience satisfaction.

Current State and Challenges of Spiritual Care in the ICU

Clinical practice guidelines recommend the spiritual support of critically ill patients.^{6,55} The Joint Commission on the Accreditation of Healthcare Organizations emphasizes respecting "cultural, psychosocial, and spiritual values" of patients.^{56(p83)} The Canadian Council on Health Services Accreditation also underscores "the client's physical, mental, spiritual, and emotional needs" and respecting "the clients' cultural and religious beliefs."^{56(p83)} Likewise, the American College of Physicians believes that physicians should pay "attention to psychosocial, existential or spiritual suffering."^{16(p355)} Despite these recommendations, spiritual care delivery as a whole is suboptimal. For instance, Balboni et al reported that while patients, physicians, and nurses all acknowledged the importance of spiritual care, spiritual care was delivered by a physician or nurse to patients with cancer in only 6% and 13% of cases,

respectively.²⁷ In addition, in their convenience sample of 188 physicians and 289 critical care nurses in the ICU, clinicians rated themselves poor at delivering spiritual care.⁵⁷

Several barriers may account for this lack of spiritual care delivery in the ICU. For one, physicians may often miss opportunities to address spiritual concerns with patients and their family. In one analysis, fewer than 20% of goals-of-care conferences in the ICU discussed religious or spiritual considerations.³⁴ Furthermore, patient or family religious or spiritual preferences were only superficially explored. Several authors have suggested that this finding may be related to a lack of time as well as a lack of training aimed at developing the skills to detect patient spiritual needs.^{19,27} The inability of physicians to elicit spiritual needs from patients also may be confounded by patient preference. MacLean reported that in a primary care setting, a “substantial minority of patients” preferred to talk about spiritual matters with physicians.^{25(p38)}

Another barrier that may prevent adequate spiritual care is underutilization of chaplains who are specially trained to attend to patients’ spiritual needs. As noted above, the inability to screen for spiritual distress by physicians may limit patient referrals to SCPs.⁵⁸ In an analysis of 13 health-care institutions, a small minority of referrals to chaplains originated from physicians, potentially indicating suboptimal delivery of spiritual services.⁵⁹ Indeed, Choi et al observed that chaplains visited 5.9% (248 of 4169) of total ICU patients, yet they visited 80% (197) of the 246 patients who died in the ICU.⁶⁰

Compounding the underutilization of chaplaincy services is poor communication between health-care professionals and limited physician–chaplain collaboration.⁶¹ Choi et al reported chaplains only spoke with physicians after 5.6% of patient encounters.⁶⁰ In contrast, chaplains communicated with nurses after 56% of patient encounters. In 22% of encounters, there was no recorded communication at all. Without improved communication, efficiency and quality of spiritual care suffer.

Finally, patients who are obtunded may not derive benefit from spiritual care. Conditions such as delirium, coma, stupor, severe dementia, some mental health disorders (eg, psychosis), encephalopathy, or global cerebral dysfunction, as well as altered level of consciousness resulting from the use of medications including, but not limited to, sedative-hypnotic agents and opioids may limit the role of spiritual care in affected patient populations. Nevertheless, there may be benefits for family members who appreciate some form of spiritual care (eg, chaplain prayer) is being delivered to the patient. Moreover, health-care professionals can play supportive roles in addressing the spiritual care needs of family members of all critically ill patients as families experience the challenge of critical illness.

Opportunities for Spiritual Care Expansion in the ICU

Chaplaincy Services

Improving spiritual care delivery in the critical care setting requires an understanding of chaplains, their training, and the

resources they contribute to patient care. Understanding these facets may help critical care practitioners expand their use of chaplaincy services. In general, patients are receptive to referrals to pastoral professionals regarding spiritual issues, and many welcome spiritual or supportive interventions from chaplains.^{48,62} Despite the paucity of regular chaplain visits, growing evidence underscores the benefits of chaplain visits on end-of-life and ICU patients. Physicians are in an optimal position to help promote more frequent chaplain–patient interactions. Referrals to chaplains may have a positive impact on patient well-being.

In the United States, more than half of the hospitals offer chaplaincy services.⁶³ Hospital chaplains are health-care professionals who provide spiritual care for people who are suffering, including patients, family, and staff.^{64,65} Chaplains have been defined as “spiritual caregivers in health care institutions.”^{56(p81)} Unlike local clergy, they are trained to work in the intense medical setting. They have been educated and certified to help patients cope and are affiliated with their religious faith group, chaplaincy organization, and employer. Professional chaplain certification usually requires a graduate theology education, faith group endorsement, clinical pastoral education, clinical competency, continuing education requirements, adhering to the code of professional ethics and professional growth.⁵⁶ The “Common Standards for Professional Chaplaincy” details specific accreditation requirements, including “a minimum of four units of Clinical Pastoral Education (CPE).”^{66(p2)} US Department of Veterans Affairs (VA) chaplains require a minimum of two CPE units before they may practice in a VA facility.⁶⁷ Hospitals, particularly in rural areas, also hire local clergy and nonboard-certified chaplains.⁵⁹

Hospital chaplains are involved in many activities.⁵⁶ They reaffirm religious beliefs and faith, although they serve all faiths and may not proselytize. Chaplains participate in non-religious spiritual care as well.⁶⁸ They listen closely to and try to understand people’s distress and serve various roles including grief and loss care, risk screening, spiritual assessment, communication with caregivers, facilitation of staff communication, conflict resolution, assistance with decision-making, and staff and institutional support.⁵⁶ They offer spiritual perspectives during medical rounds and patient care conferences. In addition, they lead religious ceremonies of worship and ritual, provide advice pertaining to health-care ethics, educate the health-care team and community about spiritual issues, and mediate or reconcile parties such as between institutions and patients, family members, and staff. Furthermore, they can serve as contact persons for complementary therapies, and some conduct research in spiritual care. They may be present at medical disclosures for adverse events and medical errors to support the value of human-centered care.⁶⁴ They are skilled listeners and skilled in communication and emotional intelligence.⁶⁹ Emotion enabling is a commonly applied technique, in which the chaplain invites the patient or family member to share feelings. Another popular activity is life review, which involves helping patients find meaning in life and decrease

anxiety. Although trained to be nondirective, chaplains may also provide pastoral counseling as appropriate.

Chang and colleagues have described chaplaincy in VA facilities. Chaplains provide an array of services, including religious, spiritual, emotional, family, and illness-related aspects.⁷⁰ Coming from various backgrounds and faiths, chaplains may be familiar with the special needs of veterans, such as their war experiences, and also be involved in bereavement care and family support. Chaplains participate in both religious and nonreligious activities. They are responsible for “performing religious rituals and ceremonies, offering religious materials and prayers, being present, being an empathetic listener, helping patients heal and reconnect with God, assisting in creating a legacy, facilitating communication among patients and family members, assisting in resolving relationship issues, helping patients accept illness and death, providing counseling, and making funeral arrangements.”^{66(p275)}

Chaplains use various novel approaches and tools to provide the aforementioned services. These techniques have the potential to enhance communication and may help to link SCPs with intensivists toward a common understanding.

A recent study attempted to standardize the chaplain’s terminology for spiritual care services, based on chart research, input from chaplains, and direct observations.⁷¹ The researchers devised a 100-item taxonomy of chaplain activities and outcomes of these activities. The taxonomy connects major themes and can be used to support patient care plan communication among chaplains and between chaplains and other health professionals. This report demonstrates an effort to introduce some element of standardization to the documentation of and communication about spiritual care assessments and interventions.

Berning et al have described the use of picture guides to assist with spiritual care in critically ill, mechanically ventilated patients.⁷² The pictures, which are simple drawings organized in categories, aided in visual communication for understanding the patient’s feelings and spiritual beliefs when they were unable to verbally communicate. In addition, these tools allowed chaplains to know what kinds of services the patient desired. They also serve therapeutic purposes by reducing patient stress and anxiety.

In an analysis of health records, ICU chaplains commonly documented the discussion of “patient and family practices, beliefs, coping mechanisms, concerns, emotional resources and needs, family and faith support, medical decision making and medical communications.”^{73(p134)} These items, which often are not addressed by other health-care professionals, were important for health-care team discussions of holistic ICU care. It is important to note, however, that there may be some variability in the quality with which chaplains document and the value it adds to patient care. For example, another report found chaplains at their institution’s ICU used mechanical language in the medical record that did not fully illuminate the patient’s narratives.⁷⁴

Table 2. Strategies and Tools for Critical Care Physicians.

Strategy/Tool	Description
Open-ended interview	<ul style="list-style-type: none"> – Open-ended questioning – Active listening – Focusing on nonbiomedical concerns and needs – Empathic responses
FICA framework	Spiritual assessment tool that guides questioning based on 4 categories: <ul style="list-style-type: none"> – Faith and belief – Importance and influence – Community – Address in care
HOPE framework	Spiritual assessment tool that guides questioning based on 4 categories: <ul style="list-style-type: none"> – H: Sources of Hope – O: Organized religion – P: Personal spirituality and practices – E: Effects on medical care and end of life

Strategies for Critical Care Physicians

Intensive care unit physicians should be mindful of the spiritual needs of their patients.⁴⁵ Studies have explored various ways in which physicians could directly participate in the spiritual care of patients and relatives of patients. Intensivists can apply these general guidelines while interacting with patients in the ICU (Table 2).

Simple changes in interview style may help clinicians determine the spiritual needs of their patients. Lo et al presented a myriad of recommendations for physicians who interact with patients about spiritual issues.⁷⁵ They proposed a stepwise interview structure. First, they recommend asking open-ended questions to determine how patients associate a medical situation with specific spiritual beliefs. The authors emphasize that active listening will then yield important information about patient spiritual and religious beliefs. After listening to their response, the authors suggest that physicians follow-up with further questions of clarification to learn more about patient beliefs and acknowledge their concerns as common or normal. Next, physicians can respond with empathic comments that demonstrate an understanding of their situation. Finally, physicians can inquire about patient emotions in order to develop a better understanding of their preferences in a specific situation.

Lo et al also provide suggestions for discovering spiritual and religious concerns less easily elicited from patients.⁷⁵ They caution physicians against immediately taking a biomedical approach in answering open-ended statements by patients, when it could be possible that the patient wants to find meaning through spiritual beliefs. An alternative would be to respond with open-ended questions or inquire further about the patient’s beliefs. Empathically conversing with the patient underscores that the physician understands and compassionately cares about the patient’s difficult situation. It also enables the physician to pinpoint the patient’s feelings and any spiritual suffering. On the other hand, actions that should be avoided include

attempting to fix the patient's problems, especially if they are spiritual. Physicians should not impose their own beliefs. Finally, physicians should not provide premature reassurance, such as stating that cancer is not a punishment from God. Instead, they could just listen attentively and acknowledge the patient's spiritual pain.

Finally, Lo et al consider instances in which the patient or family dismisses the physician's recommendations due to religious reasons.⁷⁵ Rather than emphasizing biomedical facts or manipulating spiritual beliefs to reinforce their argument, which may provoke distrust and are often futile, physicians could instead try to explore and understand their spiritual views. Once the patient's or family's views have been clarified, the physician could then find common ground to align with the view and share hope. From there, the physician may inquire about the influence of these religious views on other aspects of medical treatment and proceed to asking about other hopes for the patient. Through end-of-life conversations, the physician achieves several goals. These include illuminating the beliefs and spiritual needs of the patient, connecting with the patient, establishing shared goals and arriving at agreements, and organizing patient support such as prayers.

Another simplified, algorithmic approach is suggested by Sulmasy.⁴⁵ The authors advocate direct inquiry into a patient's spiritual needs. If the patient does not express any spiritual needs, then no further questions are necessary. But if the patient has spiritual concerns, then the physician should refer the patient to a professionally trained SCP such as a chaplain. The authors mention four general scenarios between physician and patient and potential actions to take for each scenario. If both physician and patient are religious, they can talk about religion with respect to healing, unless there are too many religious differences. If both are not religious, then they may speak little about religion and instead focus on addressing spirituality, though it may be difficult to address these needs. If the patient is religious but the physician is not, then the physician should inquire about, engage in conversation, and encourage the patient's beliefs. If the physician is religious but the patient is not, then the physician must respect the patient's beliefs and be careful not to proselytize. Given the range of religious traditions, belief systems, and expressions of spirituality, this algorithm can function as a guide but may not be applicable in all settings.

The use of a spiritual care assessment tool may also be helpful to assess spirituality. Although originally described in the outpatient oncology setting, the Faith and belief, Importance and influence, Community, and Address in care (FICA) framework could, in some circumstances, be used in ICUs.⁷⁶⁻⁷⁸ The FICA questionnaire has been shown to provide valuable information about a patient's spiritual preferences and beliefs and has been found to correlate with information obtained by established quality-of-life tools. Similarly, the **H**—sources of hope, **O**—organized religion, **P**—personal spirituality and practices, and **E**—effects on medical care and end-of-life questionnaire has been used to facilitate spirituality assessment in the primary care setting.⁷⁹ By posing questions to the patient

using these frameworks, physicians could learn more about the spiritual and religious beliefs of the patient, along with their needs or desires.

Formal spiritual care training programs targeting clinicians are available and have been reported to be beneficial in improving spiritual awareness, sensitivity, and language.⁸⁰ Although this may not be feasible for the majority of practitioners, those with special interest in spiritual care may consider further training.

Future Directions

There are many unanswered questions and many opportunities for further investigation into spiritual care delivery and its impact in the ICU. Fundamental to improving spiritual care delivery is improving spiritual care education. The development of medical school and nursing school curricula targeted at identifying and addressing spiritual care needs could have a profound impact on patient care.

In addition, identification of those in the ICU who need spiritual care is also an area that could use more examination. Although tools and acronyms have been developed to identify those in need of spiritual care in the outpatient setting, ICU specific tools are lacking. Spiritual care delivery could be improved by the development of such a tool that takes into consideration a patient's potentially compromised ability to communicate. A novel approach could be to also incorporate family member and physician/health-care professional input.

Another relatively unexplored area that needs further investigation is the spiritual care needs of health-care professionals. As noted previously, physicians and nurses are at an increased risk of burnout in the ICU. Working to identify those who are at risk for burnout and to see how spiritual care could improve burnout will be vital in improving overall care in the ICU.

Research into making spiritual care more visible in daily care is necessary as well. The ICU has benefitted from the development of standardized and systematic checklists. Pilot studies to investigate the impact of incorporating spiritual care into these checklists would be worthwhile and also provide the opportunity to investigate whether improved spiritual care has objective health benefits beyond those discussed previously.

Conclusion

Critically ill patients and their families often have spiritual needs and benefit from spiritual care. Intensivists and other critical care health-care specialists can foster a spiritually supportive atmosphere by directly discussing spiritual concerns with patients and their loved ones and utilizing available SCP services in hospitals. Chaplaincy services can greatly expand the delivery of spiritual care and the numerous benefits that are associated with spiritual attentiveness. Because of the positive outcomes attributable to spiritual care, intensivists should be aware of and offer spiritual care referrals for patient-chaplain and family-chaplain spiritual discussions.

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