

# Barriers to Addressing the Spiritual and Religious Needs of Patients and Families in the Intensive Care Unit: A Qualitative Study of Critical Care Physicians

American Journal of Hospice  
& Palliative Medicine®  
1-6  
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DOI: 10.1177/1049909120970903  
journals.sagepub.com/home/ajh  


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## Abstract

**Objectives:** Though critical care physicians feel responsible to address spiritual and religious needs with patients and families, and feel comfortable in doing so, they rarely address these needs in practice. We seek to explore this discrepancy through a qualitative interview process among physicians in the intensive care unit (ICU). **Methods:** A qualitative research design was constructed using semi-structured interviews among 11 volunteer critical care physicians at a single institution in the Midwest. The physicians discussed barriers to addressing spiritual and religious needs in the ICU. A code book of themes was created and developed through a regular and iterative process involving 4 investigators. Data saturation was reached as no new themes emerged. **Results:** Physicians reported feeling uncomfortable in addressing the spiritual needs of patients with different religious views. Physicians reported time limitations, and prioritized biomedical needs over spiritual needs. Many physicians delegate these conversations to more experienced spiritual care providers. Physicians cited uncertainty into how to access spiritual care services when they were desired. Additionally, physicians reported a lack of reminders to meet these needs, mentioning frequently the ICU bundle as one example. **Conclusions:** Barriers were identified among critical care physicians as to why spiritual and religious needs are rarely addressed. This may help inform institutions on how to better meet these needs in practice.

## Keywords

spiritual care, end-of-life care, intensive care, hospice and palliative care

## Introduction

While the majority of Americans consider themselves both spiritual and religious, modern definitions of these terms are evolving to better accommodate individual belief systems and the changing religious landscape of the West.<sup>1</sup> The International Consensus Conference on Improving the Spiritual Dimension of Whole Person Care defined spirituality as “a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature and the significant or sacred.”<sup>2</sup> Religion has been defined as “beliefs, practices and rituals related to the transcendent . . . an organized system of beliefs, practices and symbols designed (a) to facilitate closeness to the transcendent, and (b) to foster an understanding of one’s relationship and responsibility to others in living together in a community.”<sup>3</sup> Spirituality has powerful effects on the health of patients, from influencing coping with pain and suffering to improving patient-centered disease outcomes.<sup>4</sup> Physicians can uniquely engage patients on spirituality in times of suffering, and by

assessing spiritual needs can better understand their patient’s medical preferences.<sup>5</sup>

The value of addressing spiritual and religious needs extends to patients and families in the intensive care unit (ICU).<sup>6</sup> As patients reflect on the possibility of dying, many desire to be engaged on religious beliefs.<sup>7</sup> End-of-life decision making is influenced by the religious views of patients and families.<sup>8,9</sup> The moment of death is a fundamentally spiritual experience for families, who use moments of silence, bedside prayer and personal tributes to process through grief.<sup>10</sup> The quality of spiritual care is of high importance to

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families when reflecting on the quality of critical care received as a whole.<sup>11-13</sup>

Regulatory bodies in medicine recognize the importance of addressing religious and spiritual needs. The Joint Commission requires an assessment of spirituality in all admitted patients, particularly among those nearing the end of life.<sup>14</sup> Practice guidelines and policy statements from both the American College of Critical Care Medicine and American Thoracic Society recommend addressing spiritual concerns in the provision of comprehensive care to the critically ill patient. While the American College of Critical Care Medicine reports that “the chaplaincy service carries the lead position in providing spiritual assessment and care,” these regulatory bodies expect all members of the healthcare team to participate. It is not suggested that these evaluations need to be performed by a particular discipline.<sup>15,16</sup>

While critical care physicians believe it is their responsibility to address these needs, and even report feeling comfortable in doing so, they rarely address these needs in practice.<sup>17</sup> We seek to better understand this discrepancy by exploring physician barriers to addressing the religious and spiritual needs of patients and families in the ICU.

## Methods

Interviews were obtained among 11 critical care physicians at an academic research institution in the Midwest. Forty-one physicians received 2 e-mails 1 month apart to volunteer. Among the 41 physicians, 24 were attending physicians (21 male, 3 female) and 17 were fellows (13 male, 4 female). Participants completed demographic sheets that included gender, race, level of clinical service, religious affiliation, self-reported religiosity/spirituality and regularity of attendance at a religious service. The sheets were collected after completion of the interviews. Two researchers (KC and CW) conducted semi-structured interviews lasting approximately 30 minutes, outlined below (See Table 1). The 2 interviewers, KC and CW, were a primary care physician and a chaplain. Approval for this research was obtained from the Institutional Research Board at the University of Michigan.

Physicians were asked if they felt responsible to address the spiritual and religious needs of their patients and families. They were then asked to identify barriers to addressing these needs, and particular challenges they face unique to the critical care unit. At the end of the interview, physicians were free to brainstorm ways to improve the provision of spiritual and religious care to patients in the ICU. The interviews were recorded, transcribed verbatim, and stored electronically for further analysis. Each interview was given a numeric code and identifying information was removed.

This research utilized a grounded thematic analysis. All interviews were read independently by the principal investigators (CA, CW, KC, PC) to begin identifying themes. In addition to a primary care physician and chaplain, an internal medicine resident and a pulmonary/critical care attending physician were involved. The principal investigators convened to create a

**Table 1.** Selected Interview Questions.

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1. Recent research conducted at Duke University found that critical care providers felt it was their responsibility to address the religious and spiritual needs of patients and families. They also stated that they felt comfortable with providing such care. How does this compare with your perspective and experience?
  2. If not your responsibility, whose responsibility is it?
  3. If you feel it's your responsibility but you don't feel comfortable, what would be helpful to you to feel capable of addressing issues of spirituality?
  4. These clinicians also stated that while they feel comfortable addressing religious and spiritual issues, they rarely do it in practice. What do you think are some of the barriers to addressing spiritual needs of patients and families?
  5. If part of your role and equipped, what prevents you from being able to provide this care?
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preliminary code book of themes. They then tested these themes for reliability by coding interviews 1 and 2. The investigators then reconvened to further refine the code book of themes. Once consensus was reached with the first 2 interviews, each investigator individually coded the remaining interviews. Data saturation was reached at interview 9 as no new themes emerged. The interpreters then assembled in a regular and iterative process to explore and modify the identified themes until they reached consensus, selecting representative quotes as examples.

The concept of “reflexivity” was incorporated into the data-gathering and analyzing process to ensure high standards of qualitative investigation. This concept recognizes that researchers influence the outcome of qualitative research through their own backgrounds and beliefs.<sup>18,19</sup> Interviewers who do not perform clinical care in the critical care unit were selected. Though interviewers carried their own perspectives on addressing religion and spirituality in the intensity care unit, the consistent, semi-structured design of the interviews reduced the likelihood of bias. Involving 4 investigators from multiple fields and levels of training allowed for a wider variety of perspectives to be considered. Through the iterative process described above, conclusions about provider perspectives were regularly challenged and critiqued until consensus was reached.

## Results

The demographic characteristics of physicians enrolled in the study are displayed in Table 2. Seven full-time faculty and 4 fellows volunteered to participate, and of the participants, all were male and the majority white. While not a diverse sample, the demographics did reflect the demographics of physicians within the medical critical care unit at our institution. Interviewees generally considered themselves to be more spiritual than religious. A majority of participants identified themselves as Catholic, Protestant, or Jewish. The remainder were either atheist/agnostic or reported no religious affiliation. Five main

**Table 2.** Volunteer Demographics.

Variable	n (%)
<b>Gender</b>	
Male	11
Female	0 (100)
<b>Race</b>	
White	8 (73)
Black	1 (9)
Hispanic	0
Asian	2 (18)
Other	0
<b>Level of Training</b>	
Fellow	4 (36)
Attending	7 (64)
<b>To what extent do you consider yourself a religious person?</b>	
Very religious	1 (9)
Moderately religious	3 (27)
Slightly religious	2 (18)
Not religious at all	5 (45)
<b>To what extent do you consider yourself a spiritual person?</b>	
Very spiritual	3 (27)
Moderately spiritual	3 (27)
Slightly spiritual	5 (45)
Not spiritual at all	0
<b>What is your religious affiliation?</b>	
None/Atheist/Agnostic	4 (31)
Jewish	1 (8)
Muslim	0
Protestant	3 (23)
Roman Catholic	3 (23)

themes emerged from the interview process, with representative quotes selected.

### *Discomfort in Engaging Patients With Discordant Religious Views*

Clinicians cited discomfort in discussing religion and spirituality with patients whose religious beliefs differed from their own. This was particularly mentioned by interviewees when religious views influenced families and patients toward more aggressive treatment at the end of life.

“if someone, if the patient or family had a different religion than your own, that you didn’t know enough about it to address it in any kind of meaningful way so that might be a barrier um . . . and if one isn’t, doesn’t see religion as an important part of their day to day existence then then even if I could see even if a patient and family brought that up ah. it could make the provider uncomfortable to discuss it in those kinds of terms.” (Interview 8)

“You know I think I’m really fearful of, based on my own insecurities with just like offending someone, you know, or like saying something like “oh shoot” like I should put my foot in my mouth kind of thing, so not the most comfortable specifically with like,

like maybe faith groups I’m not very familiar with. You know we’ve had several people of, of like the Muslim faith in the ICU and that was sort of new to me and it was like, I don’t really know what to say and I’m worried if I say, you know, so I don’t know probably it’s my own insecurity.” (Interview 11)

### *Time & Prioritization*

Some interviewees felt that time constraints limited their ability to engage in spiritual conversations with patients and families, instead prioritizing biomedical needs.

“sometimes by necessity we really focus on the physiology and more concrete medical care because what we’re supposed to do first and foremost and it’s also people are much more comfortable dealing with things they can make sense of . . . right, in med school you learned a lot about controlling people’s blood pressure and giving antibiotics than you do about spiritual care, at least I did.” (Interview 1)

“and so logistically, then you have to have 4 conversations that take up 75 minutes of your day, and then you’re like . . . there’s other people who you also have responsibilities to . . . and so I think that in the hierarchy of obligations, this is something that while I feel it is part of the job, takes a backseat from a logistics standpoint.” (Interview 2)

### *Lack of Standardized Reminders/Checklists*

Multiple physicians mentioned the lack of regular reminders to address patients’ spiritual concerns, giving the example of the ICU bundles.

“I had mentioned . . . have it be part of the ABCDE . . . we get down to F for Foley and feeding and family . . . and G is maybe God so we can just add it to the list . . . and have that be one of the things that we sort of thing about for every patient so that if there is an issue” (Interview 2)

“the other thing is we had this ABCDEFG . . . Checklist that grows longer by the day . . . and it seems . . . at some point it’s going to get so long and unwieldy that it’s useless, but apparently that points not now, so I think if we can get to R for religious needs . . . multidisciplinary rounds are always better . . . the problem is they’re hard to bring together and you run the risk if you get everyone there of having issues” (Interview 5)

“I think that often the nurses do volunteer that kind of information because they do attempt to serve as patient and family advocates in many circumstances but we have not required them . . . the ABC-DEF, the f is families but it isn’t family subheading spiritual needs. It could be configured in such a fashion” (Interview 10)

## Specialization

Specialization of spiritual care was cited as a barrier among clinicians. As our subjects felt relatively less well-equipped, they reported deferring to spiritual care professionals for these conversations.

“I think part of being at an academic institution or a large institution with lots of resources and multiple disciplines is that we can use those different subspecialties like spiritual care, and I think if they’re available and able to do a better job than I am then it’s probably better for the patients and family members if they did it.” (Interview 1)

“And that’s ultimately why a lot of times I just kinda punt and say, well we have services available for that because I know that I can have sometimes about the medical issues and I think I do a good job of discussing these hard issues and transitions to comfort care etcetera, but I also know that palliative does have more experience in this with particular transitions . . . social work have these conversations all these times . . . (Chaplains) have these conversations all the time—and I think it’s foolish of me to think that I’m going to be better at all aspects of this than people that do this much more frequently . . . and actually the logistics, the nuts and bolts portion of it, because a lot of the things I do are just broad brushes . . .” (Interview 6)

## Unfamiliarity With Spiritual Care Services

Physicians frequently reported lack of clarity regarding the process of contacting the spiritual care department, and what services the department could provide.

“I think one of the barriers honestly is people not understanding exactly what spiritual care does and perhaps is, right, the whole concept of spirituality. I don’t think I’m alone in thinking having a certain preconceived notion about what it means when you sort of call the chaplain so just more maybe just sort of more education about what the services are and how people sort of take these things.” (Interview 1)

“I don’t know exactly how things work on your side, I often call for chaplains and you appear, and sometimes you’re there and I haven’t called for you, I don’t know . . . it is unclear to me exactly how chaplains work here. I do know there’s one on call 24/7 and if I need a chaplain now, that we stat page and someone shows up and that’s great, but from the non-emergent religious needs, it’s difficult because a lot of times I think you can get in there and probably, you can like chaplaincy fellow rounds or chaplaincy rounds, that would be great because you probably have a very different view on and could help with family dynamics that I might not see.” (Interview 5)

“Meaning, often once we’re having a discussion about shifting from aggressive medical support to comfort measures, often that’s when I think it . . . we say, if there’s anything we can do to provide

support maybe social workers, maybe spiritual care providers.” (Interview 7)

## Discussion

Previous research has evaluated physician barriers to address spiritual needs among terminally ill patients with cancer. Time constraints, inadequate training and a belief that spiritual care is better assessed by other team members were the most frequently cited barriers.<sup>20,21</sup> We sought to better understand barriers to addressing spiritual and religious needs among critical care physicians.

Physicians reported discomfort with discussing the spiritual needs of patients with religious beliefs different from their own. This was frequently cited in the setting of patients whose religious views promoted more aggressive care at the end of life. Previous research has compiled helpful information regarding religious influences on end-of-life care decision making.<sup>22</sup> Education and training for providers has been beneficial in increasing confidence with discussing religion and spirituality with patients with different religious and spiritual beliefs.<sup>23</sup> Likewise, integrating spiritual care training for medical trainees (both medical students and residents) has boosted confidence in engaging on these issues with patients.<sup>24-27</sup>

Many physicians felt limited by time, and prioritized biomedical needs of patients over religious and spiritual needs. One exception involved a physician who recalled taking daily spiritual rounds with his chaplain. The lack of regular reminders was frequently mentioned as an additional barrier. A solution was proposed by multiple interviewees with the ICU rounding bundle. To review, the A-B-C-D-E-F bundle consists of the following components: A—assess, prevent, and manage pain, B—both spontaneous breathing and awakening trials, C—choice of sedating medications and anesthesia, D—delirium, E—early mobility and exercise, and F—family engagement and empowerment. Adhering to these bundles in a systematic way ensures that patients have the best chance of being liberated from the ICU and brought back to a state of health.<sup>28</sup> While discussing the A-B-C-D-E-F bundle, one provider stated, “G is maybe God.” Introducing spirituality and religion into rounding checklists could emerge as a future area of investigation.

As spiritual care has emerged as its own department, clinicians may choose to delegate these conversations to more experienced providers. One physician likened a referral to spiritual care to that of physical therapy. Physicians did not know how to involve spiritual care, and reported uncertainty on what services they could provide. Physicians also reported using spiritual care resources primarily at the end of life, consistent with prior research involving chaplains.<sup>29</sup> Medical students are now working alongside chaplains at the bedside, simultaneously building confidence in addressing spiritual needs and strengthening connections with spiritual care professionals.<sup>30,31</sup>

While we found these 5 distinct themes through our qualitative analysis, there appears to be a common thread that reveals the ways in which these ICU physicians conceptualize religion and spirituality in the clinical setting. Many of the physicians identified external factors that may impede or aid in their ability to address spiritual needs. Time constraints, checklists, and the integration of spiritual care services are all external barriers reported, challenging the notion that the core identity of a physician is that of a holistic healer. Balboni et al. describe several models of integration between medicine, spirituality and religion. One model they describe is a whole-person care model that “emphasizes teamwork among generalists and spiritual professionals.” A complementary model presented is an existential functioning view, where clinicians are each tasked with promoting physical, psychological, and spiritual health.<sup>32</sup> The themes we found through our qualitative study seem to align with the former model. The physicians focused primarily on systems issues to improve spiritual care, rather than on issues related to their core identity. These models are meant to be complementary, not competing. If physicians fail to view themselves as holistic healers who inherently value spiritual care as part of their vocation, addressing religion and spirituality may persistently be seen as optional, even if spiritual care services are available.

Limitations include the fact that this was a single center study from an academic institution in the Midwest. Physicians from community or faith-based hospital systems may report different barriers. The large Muslim population in southeast Michigan is unique to this institution. As we had no Muslim physicians volunteer for our study, the barriers we report may differ from more religiously homogenous areas of the country. Physicians interviewed were notably all male, and predominantly white, limiting our studies’ generalizability. Gender diversity was limited by the demographics of ICU physicians at the institution and the voluntary nature of the study. Physicians entering on a volunteer basis also opens an opportunity for bias among sampling. We were able to recruit volunteers with various religious views to build diversity into our study.

In conclusion, critical care physicians report barriers in addressing religious and spiritual needs within the ICU. Common barriers include discomfort with patients from different religions, lack of time and prioritization, lack of reminders, specialization of spiritual care and lack of understanding of the process to involve the spiritual care department. This study may provide clarity to institutions seeking to identify areas of intervention to better adhere to The Joint Commission and critical care regulatory body recommendations.

### Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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