COVID-19 Articles Fast Tracked Articles

The Urgency of Spiritual Care: COVID-19 and the Critical Need for Whole-Person Palliation

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Abstract

The coronavirus disease 2019 (COVID-19) crisis has amplified the importance of palliative care to countless patients suffering with and dying from this disease, as well as to their families, communities, and the worldwide cadre of overburdened health care workers. Particularly urgent is the need for spiritual care specialists and generalists to address spiritual suffering given the degree of isolation, loneliness, and vulnerability caused by this pandemic. Although spiritual care has long been recognized as one of the domains of quality palliative care, it is often not fully integrated into practice. All disciplines are ultimately responsible for ensuring that spiritual care is prioritized to improve quality of life and the experience of patients and families facing spiritual emergencies amid the complex life-and-death scenarios inherent to coronavirus disease 2019. Although the pandemic has revealed serious fault lines in many health care domains, it has also underscored the need to recommit to spiritual care as an essential component of whole-person palliative care. J Pain Symptom Manage 2020;60:e7–e11. © *2020 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Spiritual assessment, spiritual care, chaplaincy, palliative care, COVID-19

Palliative care during the coronavirus disease 2019 (COVID-19) pandemic has cast a light on many things our field does exceedingly well. Palliative care teams, still underused and misunderstood in many settings, have become an invaluable asset to overwhelmed and beleaguered clinicians during the current COVID-19 crisis. Our specialist teams excel in offering symptom management advice, using communication skills to support isolated and rapidly declining patients, and facilitating conversations with family caregivers prohibited from entering clinical units. As staff in intensive care units (ICUs) and other acute care settings experience increased exposure to end-of-life care during COVID-19, the holistic approach and skills of palliative care teams are becoming better understood and more deeply appreciated than ever.

The pandemic and formerly unfathomable strain on health care systems also afford the field of palliative care an acid test of our capacities and a chance to hold up a mirror to honestly see not only our strengths but also our fault lines. One area that has become evident to many palliative care clinicians is our inability to truly provide the level of spiritual care needed during this crisis. Spiritual care, a well-recognized domain of our field,[1–6] is being tested like steel in a blazing fire. Although there are profound stories of the spiritual care being provided, many clinicians, patients, and families also have been exposed to a health care system that has not fully recognized the commitment to whole-person care, which is a cornerstone of our field.[7] This pandemic offers an opportunity for reflection on the true intent of palliative care, including the

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importance of spiritual care, and recognition of the work yet to be done.

No Atheists in the Foxhole

The often-quoted phrase that there are no atheists in foxholes holds meaning in a health care crisis, which has come suddenly and presents as a disease with limited available treatment, expanding rapidly, and threatening the lives of the clinicians and patients. During this time of war, the thin veil between us (the clinicians) and them (the patient) has fallen, and clinicians without adequate protection have become vulnerable victims of the same disease. The battleground is both pervasive and invisible; an airborne aggressor circulates freely among us. The possibility of death, potentially soon, has become the awareness of the new graduate nurse, the medical resident, and others barely beginning their careers and who now are facing the ultimate existential awareness of *this could be me*.

Chaplains—far too few and far too stretched amid the enormity of needs—are often limited in their ability to meet the needs of seriously ill patients and have limited time to support staff. For example, as of 2018, the National Palliative Care Registry™ identified only 54.4% of adult and 48.1% of pediatric palliative care programs in the U.S. had a chaplain member (figures based on the national 2018 inpatient hospital survey comprise 425 participating adult programs [92% not-for-profit hospitals; 51% teaching hospitals] and 54 pediatric programs [85% not-for-profit hospitals; 100% teaching hospitals]).[8] Furthermore, a minority of participating programs reported having a full core interdisciplinary team (e.g., physician, nurse or advanced practice nurse, social worker, and chaplain), at 41% for adult and 37% for pediatric programs. Given these figures before COVID-19, it is understandable that the situation has likely worsened. Ultimately, frontline providers are ill resourced and too poorly staffed to provide the spiritual care essential to whole-person palliative care.

Spiritual Care in the COVID-ICU and the Public Sphere

There have been profound images throughout media reports of patients dying with no family present in the ICU, with desperate and compassionate attempts by clinicians to respect the sacred time of dying. Rabbis, imams, priests, and other spiritual care providers are frantically sought to offer prayers, blessings, pardons, and chants. And often in the absence of any spiritual care provider, observers might assume that bedside clinicians do all they can to offer comfort as death approaches. Yet for many, spiritual care is absent, given the very real limitations and demands. The masked face of a young nurse holding her own gloved cell phone as a faith leader remotely offers a blessing to a dying patient from afar is a frequent image that offers both comfort and angst. On one hand, there is comfort in the patient being cared for, held, and supported. And on the other hand, there is the excruciating absence of faith communities and loved ones that technology falls short in replacing.

As COVID-19-related deaths have increased globally, there is a widening chasm between the experience of suffering in the outside world and the inside world of patients, families, and clinicians. For instance, the images of care in the ICU are also accompanied by the stark realities of life beyond the ICU. We see caskets being stacked in storage buildings as funeral services are not possible. There is also an emerging awareness that each ill patient in the hospital signifies a family that is not receiving bereavement support. These examples are reminders of the unmet spiritual care needs that any palliative specialist would consider among the most fundamental to practice. Social media shares images, words, and stories that speak of suffering and spiritual distress. One simple yet profound image was taken in a grocery store, depicting not the lack of hand wipes or toilet paper but rather the greeting card aisle with not a single sympathy card remaining. In the aisle of the grocery store, the public realizes—this is real—and this could be me. Yet, the level of discomfort felt by society at large is likely only a morsel of the spiritual distress felt by those in acute care environments amid the reverberating quakes of this pandemic.

What Have We Learned?

As multidisciplinary members of the palliative care community, we offer this reflection to share what we have learned about the importance of spiritual care. Following are thoughts about what we know now, in June 2020, that perhaps we did not quite know only a few months ago:

We have seen that spiritual care is not a luxury, it is a necessity for any system that claims to care for people—whether the people are in the bed or draped in protective gear.

We believe that although palliative care clinicians are perhaps better prepared and comfortable in providing spiritual care, when faced with a pandemic, our fault lines show our own need to improve spiritual care delivery practices, particularly for the most vulnerable and diverse communities.

We have been reminded that as clinicians who are spiritual care generalists, we are in great need of

spiritual care specialists. Although in the future, health care systems will be constrained with serious financial challenges, now is the time to advocate for an increased workforce of certified chaplains and improved collaboration with community faith group leaders.

We also believe that the past decades have produced significant resources for improved spiritual care, including clinical practice guidelines, consensus documents, spiritual screening tools, spiritual assessment tools, curriculum for spiritual care education, and abundant additional knowledge and resources.[9–13] Now is the time to revisit our true commitment to spiritual care, use and integrate existing resources, and commit as a palliative care community to enhance this aspect of our care with the same diligence that we use to pursue protective gear.

What Can We Do as a Professional Community?

First, every palliative care clinician can become more attuned to their role as a spiritual care generalist, by intentionally focusing on the quality of their therapeutic presence and communication and by learning specific skills designed to uncover spiritual concerns of patients during times of both normalcy and crisis.[13,14] This process of attunement requires routine spiritual screening for all patients. There are several tools available, some of which are quantifiable and specific to patients receiving palliative care near the end of life.[15] The FICA (faith, import or influence, community, address)[16] tool (© Puchalski) is convenient to use in any setting and may be adapted for COVID-19 specific considerations (Table 1). The BELIEF (belief system, ethics or values, lifestyle, involvement in spiritual community, education, near future events of spiritual significance for which to prepare the child) model by McEvoy is an option for pediatric care.[17]

Second, spiritual injury, spiritual distress, and suffering are likely to be exacerbated at the intersection of COVID-19, widespread health system strain, and the burden of serious illness and caregiver overload. All clinicians are responsible for identifying the need for spiritual specialty care and advocating for consultation and involvement as soon as possible. There are patient statements and questions that should alert clinicians for the need for spiritual care specialist involvement: What have I done to deserve this? I used to believe in God, but I do not know anymore. What did my life mean? What is there left to care about? No one understands. I'm scared.[18]

Next, given the complex psychosocial and spiritual impacts associated with COVID-19, as well as limited numbers of chaplains, it is vital that patients receive spiritual assessment and be invited to express themselves spiritually during encounters. Patients should be invited to express spiritual concerns, explore sources of fear and hope, and have opportunities to partake in spiritual practices that bring them comfort. The same is true for staff colleagues who may pick us—as palliative care clinicians and spiritual care generalists or specialists—as the people to share their spiritual distress with. Most often, what is required is listening attentively and demonstrating a nonjudgmental acceptance of their spiritual pain.

A general rule of thumb is that spiritual assessments should occur whenever there is a change in clinical status.[1] When considering the rapid decompensation often seen with COVID-19, clinicians should be

Table 1
The FICA Spiritual History Tool[14] (© Puchalski) With Considerations for the COVID-19 Context

Model Components[14]	Related Assessment Questions[14]	COVID-19 Considerations & Questions
F (Faith)	• Do you consider yourself spiritual or religious? • What is it that gives your life meaning?	• How has COVID-19 challenged your spiritual beliefs and practices? • Has COVID-19 and the stress you have experienced affected you in finding meaning in your life?
I (Import or influence)	• What importance does your spirituality have in your life? • How does it influence you in how you take care of your health?	• Since acquiring COVID-19, has your spirituality changed? Grown stronger? Diminished? • Are your spiritual beliefs helping you cope with this illness and the consequences of COVID-19?
C (Community)	• Are you a member of a spirituality community (e.g., faith communities, family, meditation groups, etc.)? • How does this support you?	• Have you found a way to stay connected with your spiritual community during the pandemic? • Do you feel supported by your spiritual community during this time?
A (Address)	• How would you like me as your health care provider to address these issues in your care? (*Include assessment of spiritual distress or needs and referral to spiritual care professional as appropriate*)	• Given social distancing mandates at home and visitor restrictions in the hospital, do you have any suggestions about how we can best support your spiritual needs right now? • I think speaking with one of our spiritual care specialists might help you at this time? Would it be ok for me to refer you to them?

COVID-19 = coronavirus disease 2019.

mindful to readdress spiritual needs throughout the care continuum for patients and families during escalation of illness, surrounding the time of death, and throughout the rehabilitation phase as applicable.

Given the urgent need for spiritual assessment and care, we recommend that all health care providers be educated through programs such as the Interprofessional Spiritual Care Education Curriculum.[19] This self-directed online training offers comprehensive case-based, interactive, and didactic education to inform multidisciplinary clinicians on topics, such as spiritual distress, compassionate presence, whole-person assessment and treatment, and essential communication regarding spiritual care.

Finally, we must forge innovative and clear pathways for chaplains to provide reliable spiritual care services throughout the pandemic and beyond. During COVID-19, there have been several examples of chaplains creatively adapting their model of care to respond to hospital visitor and staff restrictions. Through telechaplaincy, they attend to the spiritual struggle of patients experiencing isolation and fear.[20,21] Chaplains make comfort rounds to families camped outside hospital doors, holding vigil for their loved ones. They lead pause to remember rituals for staff, honoring the care they have given and speaking the names of those who have died, with a blessing.

Wounded Healers

There are still likely months ahead of COVID-19: resurgence of cases, complications among survivors, and the mental, economic, and social impacts of this first wave. We in palliative care are also a depleted group of clinicians, surrounded by the traumatic grief and post-traumatic stress of frontline workers who likely have no pause button to recover and who need significant support. We are the wounded healers[12]—called to recognize the sufferings of this time in our own hearts and make that recognition the starting point of our service. We need to carefully address the spiritual needs of our teams and colleagues. We are all too keenly aware of the costs of stifled grief. There needs to be a widespread professional commitment on the part of palliative care clinicians to honor, advocate for, and ensure the delivery of high-quality spiritual care for all people at all times and in all circumstances.

If not now—when all is falling around us—then when?

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