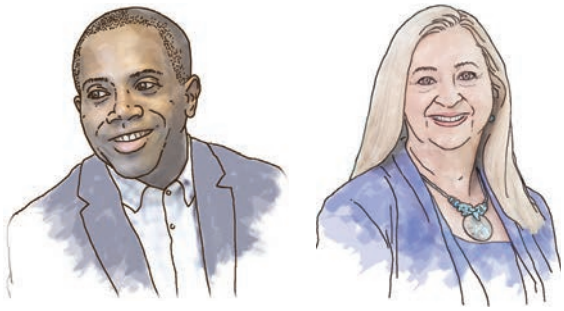
Editorial

Sacramental Moments: Presence as Spiritual Care in the Intensive Care Unit

By Aluko A. Hope, MD, MSCE, and Cindy L. Munro, PhD, RN, ANP



We can imagine critical illness quite easily as tragedy: the having to contend with a disrupted body; the life on hold; the isolation of being separated from family and friends. It can be harder to reckon with the notion of critical illness as a means to achieve a richer understanding of one's purpose, an opportunity to overcome adversity, to develop new connections with oneself, one's family or friends. Spiritual care encompasses all the ways in which we help our patients seek and express meaning and purpose during their illness journey.[1,2]

In a recent study that explored the importance of spirituality to patients and families in the intensive care unit (ICU), 85% of the respondents in a large tertiary care academic center expressed that their spirituality was important to them, particularly during moments of illness or crisis.[3] In that same study, the investigators found little evidence in the medical record, outside of the chaplains' notes, of the kinds of spiritual care that had been provided to patients. This study and others suggest that we struggle with understanding what constitutes spiritual care, how to provide it, and how to document such care in the medical record.[3] The most recent guidelines for family-centered care in the ICU recommend that patients and their families be offered spiritual care. However, those same guidelines may have contributed to the marginalization of such care by suggesting the need should be addressed by offering "chaplain services or spiritual advisors." Nurses and other clinicians have a front-row seat to many of the experiences of our patients and families, and little guidance has been offered us on how to leverage our presence to impact our patients' and families' spiritual health.

In Marie Howe's poem, "What the Living Do," the grieving narrator spends the first part of the poem remembering her dead brother and all the ways that her everyday life has been impacted by his absence.[4] Near the end of the poem, the narrator sees herself as she really is and is "gripped by a cherishing so deep" for her "own blowing hair, chapped face, and unbuttoned coat."[4] So many of us have experienced moments of "deep cherishing" for our patients, their families, or for ourselves and our families during the care we provide our patients in the ICU. Sometimes, these moments are with the patient's family, as they reminisce with each other about the patient's life, a joyful recognition that the patient had lived a good life or that they were here together because of the patient's life. Sometimes these are moments of sadness and anger, like when a daughter is finally able to say, "I forgive you" to a dying father who was the

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source of abuse and trauma. Sometimes these are moments beyond our understanding, like a patient suffering with diffuse itching and body pain who could find comfort only when her son scratched her knee as he sang her favorite song. Sometimes, these moments are extraordinary mysteries that invade a routine moment of care, or simple moments of truth that make us more aware of the patient as a united body and soul together in one being. Theologian Robert McAfee Brown calls such moments *sacramental moments*.[5] These moments make us speechless, they make us cry, or they make us go home and hug our families tighter.

One way to expand our conceptual understanding of spiritual care in the ICU is to think of ways we can better cultivate these sacramental moments to improve patients' quality of life and experience of illness. Here we propose 5 overlapping principles that we think may help us to improve the spiritual care of our seriously ill patients with our presence: attention, wisdom, resilience, creativity, and laughter.[6] *Attention* simply means we are conveying our presence to our patients with compassion and concern, without judgment. Such attention will increase the likelihood that the mundane things we do in caring for our patients can become acts of meditation or acts of love. In the ICU, because our patients are often nonverbal, attention may require us to imagine the patient, as a person, outside the confines of illness; it may require us to exchange the tidbits of data that we have accumulated about the patient with other members of the ICU care team. Of course, the biggest barrier we have to such attention is our need to fix the patient; our need to make a difference often means we devalue our skills in reading the text of the patient's life. With mindfulness, we hope that ICU clinicians can improve patients' health while paying close attention to their patients' whole stories.

About the Authors
Aluko A. Hope is coeditor in chief of the *American Journal of Critical Care.* He is an associate professor and physician scientist at Oregon Health and Science University in Portland, Oregon. **Cindy L. Munro** is coeditor in chief of the *American Journal of Critical Care.* She is dean and professor, School of Nursing and Health Studies, University of Miami, Coral Gables, Florida.

We come to clinical care with both practical and scientific knowledge along with the lived experience of having cared for patients or families through the years. *Wisdom* is not about us simply being a vessel of factual knowledge for our patients and their families. Wisdom is more about us honing an intuition for what the best course of action might be for any specific moment. Wisdom is about developing processes that allow us to grow in our capacity to connect and collaborate with our patients more effectively—our ability to reflect on what things we have tried that have been helpful and what things we have tried that have been less helpful for enhancing our patients' spiritual quality of life. Wisdom invites us to take risks, as well. For example, instead of saying no when a patient asks us to pray with them, taking a risk might involve agreeing to hold the patient's hand as their pastor prays for them. Such a risk might allow us to learn something new about ourselves or something new about our patient's capacity.

Resilience involves developing sustainable ways to care for ourselves so that we can care for the spiritual needs of our patients. We must attend to our own spiritual needs as well. We must come to grips with what we believe, what motivates us to do what we do, what tasks makes us feel most vulnerable, and what tasks we most value. Importantly, because ICU care is multidisciplinary, part of the team's resilience is in how we develop processes that allow all members of the ICU team, including learners, to have space and time to discover what they need to be their most resilient selves in the team.

Creativity is an invitation for us to think outside of the box; it is an acknowledgment that rigorous discernment allows us to develop new insights into things we are seeing or doing. It was this creativity that allowed so many ICUs during the pandemic to find ways to better connect with their patients despite the challenges that the pandemic posed for humanistic care. Nurses found ways to extend the intravenous pumps so that the titratable pumps were outside of the patients' doors, allowing them to titrate the vasopressors more quickly without having to don and doff personal protective equipment. Many ICU teams used novel telemedicine approaches to ensure that patients' families could interact with patients despite the changes in visitation

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necessitated by the pandemic. It is creativity that allows us to transcend the limitations of our organizational and societal policies to ensure that we can maximize our patients' spiritual health.

Laughter reminds us to not take ourselves too seriously and gives us the skills to reframe our most negative perceptions. Our ability to laugh at ourselves, with our work mates and with our patients, is a way to acknowledge the absurdity of illness as part of the human condition. Giving permission to our patients or their families to see the humorous side of their condition can also lead to a richer understanding of the plight of our patients and create opportunities for different types of collaboration.

Our critically ill patients may suffer and yet they need not suffer without us trying to help them make sense of their illness. We have the capacity to use our attention, wisdom, creativity, resilience, and humor to help our patients and families find meaning during the ravages of illness.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

FINANCIAL DISCLOSURES
None reported.

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