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Spiritual care in the intensive care unit

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Abstract

The aim of the present paper is to describe the real possibilities of providing spiritual care in intensive care units (ICUs) in Poland. Faced with suffering and death, critically ill patients and their families need a source of comfort and hope. Spiritual care is intended to bring relief to them by responding to their spiritual needs. The literature review indicates the positive effects of providing spiritual care in ICUs. Spiritual care improves the quality of life of patients, satisfaction with medical care and even prevents or alleviates the negative psychological consequences of hospitalization. Moreover, it is beneficial to the ICU personnel, to their motivation, work efficiency, well-being and reduces the risk of burnout. Basic spiritual care that can be provided by any ICU physician on a daily basis is nothing more than the way of behaving towards a patient: seeing an individual who has his/her dignity, history, personality, beliefs, fears and hopes. Whenever disease-associated stress has led to an existential crisis, the ICU staff may request a hospital chaplain's visit. The physician can support the conscious patient by establishing a relationship with him: by showing concern, compassion and solicituide. According to some researchers, each patient admitted to the ICU should be asked questions about spiritual issues. If faith is important to the patient, it is necessary to allow him/her to use religious resources, which requires cooperation with a hospital chaplain. The paper discusses the ways the hospital chaplaincy operates in Poland and worldwide. Furthermore, the education of chaplains abroad and the scope of their tasks and activities are described.

Key words: intensive care, spirituality, critical care, religion, religiosity, spiritual care.

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In addition to the physical symptoms of a critical disease, patients hospitalised in intensive care units (ICUs) experience many unpleasant bio-psycho-socio-spiritual sensations: anxiety, loneliness, powerlessness and fear of death or permanent disability [1]. This also applies to their families who suffer while looking at their loved ones with severe conditions. In many cases, a relationship with the medical staff provides comfort and hope to them. Moreover, for some individuals, a spiritual perspective (transcendent, beyond the visible world) makes it possible to give meaning to difficult disease-related experiences [2]. In recent years, the issue of spirituality in medicine has gained increasing attention and interest. Spiritual care has become an essential component of high-quality intensive care [1, 3–5]. The American College of Critical Care Medicine (ACCM) has even developed the guidelines for spiritual and religious support in ICUs (Table 1) [6]. The aim of the present paper is to describe the real possibilities of providing spiritual care in ICUs in Poland. Therefore, a non-systematic review of scientific literature was carried out in terms of the spiritual needs of ICU patients and staff, the basic assumptions of spiritual care, the principles of talking about spirituality, the idea of a pastoral care team and cooperation with a chaplain.

TABLE 1. Clinical practice guidelines concerning spiritual support (source [6])

Recommendation 1: Spiritual needs of the patient are assessed by the healthcare team, and findings that affect health and healing incorporated into the plan of care.
Recommendation 2: Physicians will review reports of ancillary team members such as chaplains, social workers, and nurses to integrate their perspectives into patient care. Chaplains and social workers are trained to explore spiritual issues and can provide intensivists with valuable insights into the patient's condition.
Recommendation 3: Nurses and doctors receive training in awareness of spiritual and religious issues so that they may properly assess patients and make use of findings in the plan of care written by social workers and chaplains.
Recommendation 4: If a patient requests that a healthcare provider pray with him or her, and the healthcare worker agrees to and feels comfortable with it, the request is honored and considered to be part of the spectrum of holistic intensive care.

WHAT EXACTLY IS SPIRITUAL CARE?

Spiritual care consists in identifying and addressing patients' "spiritual needs", such as the search for inner peace, the meaning of life, the meaning of suffering, hope, contact with God or "greater strength" [4, 7]. To this end, some patients should be given the opportunity to access prayer, rituals, sacraments, and other religious resources, which requires cooperation with hospital chaplains ("classic religious" care). At the same time, the medical personnel can respond to the above needs outside the religious context by providing patients with respect and solicitude (general spiritual care), particularly patients who are unresponsive. There is no diagnostic method that could demonstrate that such patients do not think or do not experience unpleasant feelings. In such unimaginably vulnerable situations, compassion is needed most [8]. This is particularly important during the current pandemic, when hospitals have imposed visitor restrictions, which means that patients spend more time without their loved ones by their side. For this reason, the Polish Association for Spiritual Care in Medicine has implemented the program "Be with me – social and spiritual support for patients hospitalized because of COVID-19" [9].

SPIRITUAL NEEDS OF ICU PATIENTS

There are sparse reports on the effects of spirituality on ICU stay. In a qualitative study carried out among 45 patients whose condition stabilised after a critical period, Hupcey [10] has demonstrated that their sense of safety depended not only on the way the personnel and their families treated them, but also on their own religious beliefs. According to Aslakson *et al*. [11], who surveyed 81 ICU patients, 88.5% of them considered their spirituality/religiosity to be an important support in dealing with the crisis. Furthermore, Piderman *et al*. [12] asked 190 ICU patients whether they would like the hospital chaplain to visit them, and if so why; 77% of patients answered in the affirmative and gave the following reasons: the need to remember God's care and the need to talk to others. Berning *et al*. [13] studied patients undergoing mechanical ventilation who communicated with the hospital chaplain using a pictogram board. Their findings have shown that 81% of them felt more able to cope with hospitalisation after the chaplain`s visit and experienced more of inner peace. Duffy *et al*. [14] also assessed ventilated patients without cognitive impairment. They used an eye-tracking device for reading aloud the words the patient directed his/her eyes to. The first pieces of information concerned basic needs of patients: pain, discharge in the respiratory tract, room temperature and bed position. Subsequently, patients could pass on any message they wanted; the need for a prayer and a chaplain's visit was then mentioned.

OPINIONS OF ICU PERSONNEL ON SPIRITUAL CARE

Willemse *et al*. [15] interviewed a total of 487 physicians, nurses and chaplains working in 85 different hospitals. More than two-thirds have seen positive effects of spiritual care for patients and their families, such as improved well-being, the ability to express emotions, and higher satisfaction with care. Moreover, the majority of respondents have stated that interdisciplinary cooperation should be increased in order to improve the provision of spiritual care. McSherry and Jamieson [16] surveyed more than 4,000 members of the Royal College of Nursing in the UK, while Noome *et al*. (Netherlands) [17] and Bone *et al*. (Canada) [18] interviewed ICU nurses. The conclusions concerning spiritual care are as follows: 1) caring for the spiritual needs of patients improves the overall quality of care; 2) in many cases, there is no time to support dying patients and their families; 3) the chaplain is a key figure in spiritual support; patients in need should be referred to him; 4) greater involvement of the management authorities is needed to enable patients' spiritual needs to be effectively catered for; 5) there are no specific recommendations on cultural and religious differences.

The situation in Muslim countries is different. Bakir *et al*. [19], surveying ICU nurses in Turkey, have noted that 44.8% of them received spiritual care education and 64.1% of them provided patients with spiritual care on a daily basis. Abu-El-Noor [20] examined the opinions of ICU nursing staff in Palestine. Most nurses associated the idea of spiritual care with religion, but also recognized that its elements were: care, being fully present, showing respect, love, and supporting the search for meaning in life. Nurses used both conversations and close observations to identify patients' spiritual needs. The length of hospitalisation, diagnosis and general conditions of patients were found indicative of the need to be provided with spiritual care. The following religious interventions were used: 1) prayer for patients; 2) help in preparing for prayer (e.g. turning the bed towards Mecca); 3) reading the verses from the Holy Quran together with patients; 4) playing recordings for unconscious patients. Moreover, non-religious spiritual interventions were undertaken: 1) accompanying severely/ critically ill patients; 2) patient listening or speaking to unconscious patients; 3) holding hands; 4) permission for longer visits of families (even at night) [20].

SPIRITUALITY OF ICU PERSONNEL

ICU physicians and nurses work under pressure associated with rapidly changing conditions of pa-

tients, the necessity to operate advanced medical technologies and legal liabilities for possible malpractice [21, 22]. The above and other factors can force them to distance emotionally from patients and their families and spend increasingly short time talking to them; moreover, lower job satisfaction and burnout syndrome can be observed under such circumstances [23, 24]. It has been shown that involvement in spiritual life can reduce the risk of developing this syndrome, as it positively affects the motivation, work performance and well-being of medical professionals [1, 4, 25, 26]. Providing spiritual support is an opportunity for the staff to show their human side and establish a satisfactory patient-provider relationship [27–29].

SPIRITUAL SUPPORT OF THE FAMILY

Basic spiritual support is naturally provided to patients by their close relatives/families through their presence, touching, and talking. Even the patients who cannot communicate with their surroundings are whispered the words of encouragement and assured about the feelings towards them. Favourite icons and religious books are brought to those who have faith; the family members pray at their bedside. In ICU, particularly during the pandemic period, this situation is somewhat reversed. Due to sanitary requirements, contact with the loved ones is significantly restricted, and therefore the role of the patient's companions is taken over by the staff. On the other hand, the family members themselves are in crisis; together with the patient they form the entity called "the collective patient" that requires care and support. The extensive literature is already available on the spiritual care of families of ICU patients, the review of which, however, is beyond the scope of this paper.

BASIC SPIRITUAL SUPPORT OF ICU PATIENTS

ICU physicians who want to support spiritually their patients do not have to take on additional responsibilities. They can provide general spiritual care by looking at their patients in a holistic manner, seeing individuals with their history, identity, dignity, beliefs, and desires [1]. Such an approach is particularly important when patients (or their families) refuse to observe certain doctor's recommendations on religious grounds. Instead of persistently persuading them to follow orders, the physician can try to see how important faith is to this individual. Listening to spiritual concerns can increase trust in the doctor; consequently common ground for action can be found [4]. Likewise, the nursing staff can show respect and understanding through simple actions. Such a case was described by Abuatiq in 2015 [30]: a conscious female patient admitted to ICU with neutropenia and infection felt very anxious. Knowing that her patient was a believer, the nurse asked whether she needed a prayer book. The patient preferred to listen to service on television. The nurse found a suitable TV channel and the patient's anxiety decreased [30].

A significant proportion of ICU patients are unconscious or have disturbance of consciousness. However, many of those who have recovered from sedation remember some excerpts from conversations held at their bedside. Thus, basic spiritual care includes appropriate behaviour during each activity performed with patients, including refraining from negative comments on their symptoms. Moreover, their sense of hearing can be used to respond to their spiritual needs, e.g. playing relaxing music during the day [30]. The patient's family can be helpful in such cases to tell which radio station the patient likes to listen to. In the study by Yadak *et al*. (Saudi Arabia, 2019), the verses of Quran were recited to religious patients to make their weaning from the ventilator easier [31].

THE QUESTION OF SPIRITUALITY

Many researchers stress the role of dialogue with patients about their spiritual beliefs [32–35]. In addition to observation, they recommend asking actively/directly about spiritual issues. They postulate not to wait for accidental mentioning of faith in a conversation. They even suggest asking such a question to each patient on admission to the hospital or to the ICU. Patients usually do not feel offended when asked such questions in a benevolent manner [36], e.g. "For some people, religion or spirituality is a source of comfort and meaning in life; is this true for you too?". If religion is important to patients and helps them cope with difficulties, the medical providers can support them in using it. However, if the patient clearly states that he/she is struggling to find the meaning of life in the face of a severe illness, the physician may facilitate his/her meeting with a member of the pastoral care team [33]. The personal beliefs of the physician confronted with the spirituality of the patient allow to arrange assistance in such a way that there is no risk of occupational abuse [33].

TALKING ABOUT SPIRITUALITY

Gordon *et al*. [32] reviewed the literature regarding actual compliance with the aforementioned ACCM guidelines on spiritual and religious support in ICUs. They have found that 10 years after their introduction, the spiritual needs of patients are very rarely assessed by physicians. Conversations about spirituality undoubtedly require special training. The number of beliefs about the meaning of life,

existence of a "higher power", meaning of suffering and possible life after death, is as high as the number of different cultures and religions, or even individual interpretations. The physician is not able to know them all, yet he/she should know that faith significantly affects the patient`s perception of and coping with the disease or disability, etc. If need be, physicians can significantly expand their competences in this field by completing special courses, during which sensitivity and the ability to build relationships are developed [32, 37, 38].

Recently, several easy-to-use tools have been developed, which facilitate the assessment of spiritual needs. For instance, FICA or HOPE described in Polish by Żołnierz can be used to take "spiritual history" [39, 40]. Their advantage is that the completed questionnaire can be attached to the medical records, where it is available to other team members. It is also of importance that an atmosphere of trust is created, without which the patient may not be able to reveal his/her inner experiences, fears and hopes. The physician can therefore try to build a relationship with the patient by suitably adapting the communication style, showing compassion, interest, sensitivity, care, and desire to alleviate his/her symptoms [41] (Table 2).

According to Sulmasy [42], there are four options for talking about faith: 1) If both the physician and the patient are religious, they can talk about religion with regard to healing/recovery, unless there are too many differences between their religions; 2) If both are not religious, they can focus on other spiritual needs; 3) If the physician is religious, but the patient is not, the physician has to respect patient`s beliefs and avoid converting the patient to his/her faith; 4) If the patient is religious and the doctor is not, the doctor should ask if he would be willing to talk to a hospital chaplain.

PASTORAL CARE IN POLAND

Article 53 of the Constitution of the Republic of Poland contains a provision on the right to receive religious support in the places where [people of faith] find themselves. Consequently, the Patients' Rights and the Ombudsperson for Patients' Rights Act [43] states that a patient staying in a therapeutic unit ... has the right to pastoral care. For this reason, hospital chaplains are employed by hospitals to deliver religious services there. Until recently, hospital pastoral care in Poland was limited to the celebration of Mass in the chapel and the chaplain's visits to patients` rooms. In recent years, a new model has begun to be developed called "pastoral care team" [44], which is much richer and more effective in supporting patients and their families, as well as medical staff. It is based on the involvement of employees and volunteers in the basic scope of spiritual care, i.e. 1) accompanying patients most compassionately, establishing relationships with them; 2) regular monitoring of spiritual needs so that patients and their relatives undergoing a spiritual crisis can be identified and referred to chaplains; 3) providing patients with access to what they need to practice their faith (the Holy Bible, prayer books, transport to the hospital chapel).

Basic spiritual care can be provided by any medical professional, yet the hospital chaplain is a specialist in this field [32, 37, 45]. The cooperation of doctors and nurses with the priest requires

TABLE 2. How can ICU workers build an atmosphere of trust during meetings with patients? (sources [4, 33, 41, 60])

Instruction	Comment
Using nonverbal methods, the doctor can demonstrate that patients and their families are important to him.	No haste, sitting position and making eye contact during the conversation, avoiding professional jargon.
It is worth not interrupting patients when they tell personal stories related to the disease.	This is a chance for the doctor to see the extent to which the disease affects life of the patient.
Some patients clearly present feelings associated with the disease when providing information about their symptoms.	Example of patient`s words: „I'm afraid I'm going to die, I don't know what's going to happen to me..."
If the patient does not talk about what he is going through, the doctor may decide to ask him an open question about it.	Example of doctors' words: "Would you like to say more about how this disease affects your life, what does it mean to you?"
Answers about internal experiences or existential doubts should be listened to "actively" (check that they are well understood on an ongoing basis).	The important elements are confirmation of reception of information, paraphrasing, asking supplementary questions.
Then the doctor can ensure that such experiences are normal and on the spot.	Example of the doctor's comment: "Many people in this situation would be angry/depressed".
He can also comment on what he heard in an empathetic way.	Example of the doctor's comment: "It's actually very sad"; "I can only imagine what a disappointment it is..."
Finally, he can assure of his/her commitment.	Example of the doctor's comment: "We will work together to achieve the goal"; "I will try to help you feel your best".

TABLE 3. Duties of a hospital chaplain (sources [4, 5, 55, 57, 61–64])

Non-religious activities	Religious activities
Initiating, developing and deepening the relationships with patients and their families through conversations, being present, listening attentively, showing compassion, understanding.	Giving the sacraments (in Catholicism) of the Eucharist (holy mass in the chapel, communion at the patient's bedside), confession, anointment of the sick (the grace of strengthening, peace and courage to overcome difficulties, to lead the sick person to healing of the soul and body) and others.
Assessment of spiritual needs, provision of information about the spiritual condition of the patient to other members of the attending team.	
Assistance in dealing with emotional pain, spiritual crisis (e.g. in the face of impending death or irreversible disability).	Praying together with the patient/family, prayers for various purposes, e.g. in the chapel, intercession prayers (laying on of hands).
Involvement in end-of-life decision-making.	
Assistance in summarising one`s life and formulating final instructions.	Preaching, e.g. annual retreat for hospital staff.
Support during the mourning period, assistance in arrangements for the funeral.	
Communication with caregivers, facilitating communication with the staff, assisting in resolving conflicts.	Speaking with a believer of the same faith, the chaplain can encourage him by reference to relevant spiritual content. For instance, the Catholic Church binds the suffering of every individual to the suffering of Jesus Christ, giving it a salvific value.
Mediation between parties, i.e. institutions, patients, family members and staff.	
Support of the medical staff by re-discovering the essence of their vocation and preventing burnout.	Affirmation of patients' beliefs about faith, according to their religion and culture (cannot convert to his religion), provision of religious materials (the Holy Bible, rosary, Torah, Quran etc.)
Assistance in solving ethical dilemmas, participation in meetings of the Ethics Committee.	
Education on spiritual care.	Build relationships with local religious communities and their leaders on behalf of healthcare organizations.
Conducting research in the field of spiritual care.	

an understanding of the scope of his training and possible contribution to daily clinical work [4]. The religious and non-religious activities carried out by chaplains are shown in Table 3. The presence of a priest in the ICU can be misinterpreted by patients and cause fears of a bad prognosis. Therefore, it is recommended that the chaplain's involvement should not be postponed until the patient's condition deteriorates and that it should not take place without the consent of the patient's family [1].

TRAINING OF CHAPLAINS ABROAD

Chaplains in Australia, the United States and Western Europe are certified laypersons and clergy, both men and women [46]. A professional chaplain's degree can be obtained by a candidate with higher education (in most cases, with a degree in theology) who has completed courses in clinical pastoral education (CPE) [45, 47], meets the requirements of continuing education and the Code of Professional Conduct [47]. He is then employed as a full member of the health care team (and not as a representative of the religious community). Consequently, the professional chaplain has access to all patient information [11].

Chaplains know the rituals and customs of many religions and ethnic groups, as well as the principles of interpersonal communication. They are prepared to help solve theological issues [45], but their special task is to provide patients with non-religious support. They assess the spiritual needs of patients and respond to them, respecting religious and cultural diversities [5, 48]. The chaplain will not ask why you do not believe in God but will seek the means to establish a therapeutic relationship with every patient, family member, and hospital worker [48, 49]. Spiritual care professionals are qualified listeners, facilitating the expression of difficult emotions [48]. A popular method of dialogue is a "life review". Such a narrative helps patients understand the importance of various experiences they encountered and reduce the extend of grief and fear [48]. In addition, chaplains are to educate the medical staff on how the believers of different religions cope with a serious illness or death [33].

COOPERATION WITH A CHAPLAIN ABROAD

In the United States, more than half of hospitals offer pastoral services [50]; their provision in ICUs was described by Brown [51]. According to him, ICU workers are usually aware of the spiritual aspects of their work but devote more time to technological imperatives. Without careful introduction, they may see the chaplain as an intruder or a "harbinger of doom" in the setting where the atmosphere is often tense. If it is not possible for a chaplain to be a permanent

member of the ICU team, the system of spiritual consultations should function efficiently. Many patients could benefit from such consultations provided that commissioning them is not postponed until the time of dying [49, 52].

The use of pastoral services is strictly dependent on communication between the medical personnel and chaplains [4]. A study conducted at Johns Hopkins Bayview Medical Center in Baltimore, USA, has demonstrated the benefits when chaplains attended every meeting of ICU staff with patient families. Such a possibility exists there thanks to well-developed hospital chaplaincy services in this facility. Eight chaplains, who are CPE residents, supervised by two chaplains-mentors, provide direct care [53]. The meetings of chaplains with ICU patients may depend on the length of stay and general conditions of patients. Choi *et al*. (Duke University Medical Center in Durham, USA) have demonstrated that chaplains visited only 5.9% of all patients hospitalized in the ICU [52]. However, analysis of the documentation of those who died in ICU has revealed that chaplains visited as many as 80% of them. It is likely that the families or ICU staff requested a chaplain`s visit when the patient`s condition deteriorated. It has also been found that after the visit, chaplains extremely rarely talked about the patient`s condition with physicians (about 5%), more often with nurses (about 56%). By contrast, in an Australian study by Carey *et al*. [54], as many as 90% of the 327 chaplains stated that it was their duty to consult the physicians on issues concerning patients and their families.

The associations of chaplains have developed appropriate standards of conduct in ICUs [55]. In at least 200 medical centres in the United States, the chaplain as a consultant records his observations in electronic documentation, which improves the transparency and quality of spiritual care. Chaplains describe the rituals, views and faith of the patient, his/her religious practices, fears, emotional resources, mechanisms for coping with stress, relationships with the family and relatives, and support on their part. A summary of the patient's spiritual condition and a care plan are thus available to the rest of the team - physicians can check whether the patient is experiencing a so-called "spiritual crisis" (the patient does not see the meaning of his life, does not care about recovery, does not want to be treated) and whether further pastoral visits are planned [5, 56–58]. Nurses can also use chaplain notes during bedside reports, which will help them to understand the association between patients' symptoms and their experiences [59]. In the case of unconscious critically ill patients, the chaplain speaks with their families. He learns whether their faith/religious practices can affect medical end-of life decision making and discusses the above issues with the attending physician, if need be.

CONCLUSIONS

In addition to their knowledge and technical skills, ICU physicians and nurses are capable of being sensitive to the psycho-socio-spiritual needs of other individuals and show compassion. They can show respect and care to any patient, regardless of their states of consciousness. Any conscious person, regardless of religious affiliation (or lack thereof), will benefit from establishing a friendly relationship with a person full of compassion. It will be a source of comfort, a sense of belonging, hope and peace for him, even in the face of poor prognosis. There are therefore many arguments in favour of the inclusion of spiritual care in standard management in ICUs (Table 4).

Spiritual care is not expensive, it does not require specialized devices, because it begins with a holistic approach to the patient. Spiritual support can be

TABLE 4. Arguments in favour of incorporating spiritual care into standard management in ICUs

The existence of spiritual needs of patients in critical condition has been documented.
Spirituality is especially important for some patients, is a part of their identity and worldview; spiritual care is therefore an indispensable part of holistic care.
Spirituality brings a sense of meaning to life events, helps to deal with suffering, gives comfort and hope in the face of troublesome ailments/poor prognosis
The provision of spiritual care has a positive effect on the quality of life of patients, increases satisfaction with care, reduces the severity of depression and posttraumatic stress disorder (PTSD) after discharge from the ICU
Mindfulness of internal experiences facilitates understanding, establishing a relationship with the patient and determining common, realistic treatment goals.
Involvement in spiritual life positively affects the motivation, productivity and well-being of doctors and reduces the risk of burnout. Dying is perceived to be a spiritual experience.
The use of spiritual care enables more frequent transfer of patients over the end-of-life period from ICUs to hospices.
Religious rituals are important for some patients and their families during the period of dying and mourning.

provided by simply talking about spirituality. This is extremely far from forcing someone to be religious or imposing one's beliefs ("forced conversion"). On the contrary, this is a step towards findings out who the patient admitted to the ICU is and whether he/she has the resources to deal with suffering. The ability to conduct such dialogues requires basic spirituality training. Cooperation with chaplains facilitates the access of believers to religious materials, but also provides professional support to any patient who needs to be strengthened in the face of a crisis. The chaplain is interested in how the patient relates his current medical condition to his spiritual beliefs. Being religious does not eliminate complaints but affects the way they are experienced (hope or despair). Religious content associated with suffering can be a source of comfort for incurably ill individuals.

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REFERENCES

1. Gualdani S, Pegoli M. Spirituality in health care: the role of needs in critical care. Trends in Anaesthesia and Critical Care 2014; 4: 175-177. doi: https://doi.org/10.1016/j.tacc.2014.09.003.
2. Klimasiński M, Theda J, Cofta S, et al. Opieka duchowa w medycynie: duchowość a postrzeganie choroby, radzenie sobie z cierpieniem – ankietowe badanie ilościowe na polskiej populacji dorosłych chorych przewlekle. Sztuka Leczenia 2020; 1: 9-18.
3. Krajnik M. Holistyczna opieka nad chorym – nadzieja dla współczesnej medycyny? Medycyna Praktyczna 2017; 9: 121-124.
4. Ho J, Nguyen C, Lopes R i wsp. Spiritual care in the intensive care unit: a narrative review. J Intensive Care Med 2018; 33: 279-287. doi: 10.1177/0885066617712677.
5. Willemse S, Smeets W, van Leeuwen E, Nielen-Rosier T, Janssend L, Foudraine N. Spiritual care in the intensive care unit: an integrative literature research. J Crit Care 2020; 57: 55-78. doi: 10.1016/j.jcrc.2020.01.026.
6. Davidson J, Powers K, Hedayat K, et al. Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American college of critical care medicine task force 2004-2005. Crit Care Med 2007; 35: 605-622. doi: 10.1097/01.CCM.0000254067.14607.EB.
7. Klimasiński M, Ziemkiewicz M, Neumann-Klimasińska N. Potrzeby duchowe pacjentów istotne w codziennej praktyce klinicznej. Medycyna Paliatywna 2017; 9: 210-217.
8. Piticaru J. Critical caring: rediscovering humanity in the intensive care unit. Pol Arch Intern Med 2017; 127: 645-646.
9. Krajnik M, Gajewski P, Gołota S i wsp. Opieka duchowa niezbędną składową całościowej opieki nad chorymi na COVID-19. Stanowisko Polskiego Towarzystwa Opieki Duchowej w Medycynie. Medycyna Praktyczna 2020; 12: 146-152.
10. Hupcey J. Feeling safe: the psychosocial needs of ICU patients. J Nurs Scholarsh 2000; 32: 361-367. doi: 10.1111/j.1547-5069.2000.00361.x.
11. Aslakson R, Kweku J, Kinnison M, et al. Operationalizing "the measuring what matters": spirituality quality metric in a population of hospitalized, critically ill patients and their family members. J Pain Symptom Manage 2017; 53: 650-655. doi: 10.1016/j.jpainsymman.2016.12.323.
12. Piderman K, Marek D, Jenkins S, et al. Predicting patients' expectations of hospital chaplains: a multisite survey. Mayo Clin Proc 2010; 85: 1002-1010. doi: 10.4065/mcp.2010.0168.
13. Berning J, Poor A, Buckley S, et al. A novel picture guide to improve spiritual care and reduce anxiety in mechanically ventilated adults in the intensive care unit. Ann Am Thorac Soc 2016; 13: 1333-1342. doi: 10.1513/AnnalsATS.201512-831OC.
14. Duffy E, Garry J, Talbot L, et al. A pilot study assessing the spiritual, emotional, physical/environmental, and physiological needs of mechanically ventilated surgical intensive care unit patients via eye tracking devices, head nodding, and communication boards. Trauma Surg Acute Care Open 2018; 3: e000180. doi: 10.1136/tsaco-2018-000180.
15. Willemse S, Smeets W, van Leeuwen E, et al. Spiritual care in the ICU: perspectives of dutch intensivists, ICU nurses, and spiritual caregivers. J Relig Health 2018; 57: 583-595. doi: 10.1007/s10943-017-0457-2.
16. McSherry W, Jamieson S. An online survey of nurses' perceptions of spirituality and spiritual care. Journal of Clinical Nursing 2011; 20: 1757-1767. doi: 10.1111/j.1365-2702.2010.03547.x.
17. Noome M, Dijkstra B, van Leeuwen E, et al. The perspectives of intensive care unit nurses about the current and ideal nursing end-of-life care. J Hosp Pall Nurs 2016; 18: 212-218.
18. Bone N, Swinton M, Hoad N, et al. Critical care nurses' experiences with spiritual care: The SPIRIT Study. Am J Crit Care 2018; 27: 212-219. doi: 10.4037/ajcc2018300.
19. Bakir E, Samancioglu S, Kilic S. Spiritual experiences of muslim critical care nurses. J Relig Health 2017; 56: 2118-2128. doi: 10.1007/s10943-017-0382-4.
20. Abu-El-Noor N. ICU nurses' perceptions and practice of spiritual care at the end of life: implications for policy change. Online J Issues Nurs 2016; 21: 6. doi: 10.3912/OJIN.Vol21No01PPT05.
21. Azoulay E, Timsit J, Sprung CL, et al. Prevalence and factors of intensive care unit conflicts: the conflicus study. Am J Respir Crit Care Med 2009; 180: 853-860. doi: 10.1164/rccm.200810-1614OC.
22. Curtis J, Burt R. Why are critical care clinicians so powerfully distressed by family demands for futile care? J Crit Care 2003; 18: 22-24. doi: 10.1053/jcrc.2003.YJCRC5.
23. Embriaco N, Azoulay E, Barrau K, et al. High level of burnout in intensivists: Prevalence and associated factors. Am J Respir Crit Care Med 2007; 175: 686-692. doi: 10.1164/rccm.200608-1184OC.
24. van Mol M, Kompanje E, Benoit D, et al. The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: a systematic review. PLoS One 2015; 10: e0136955. doi: 10.1371/journal.pone.0136955.
25. Klimasiński M, Ziemkiewicz M, Baum E. Duchowość a wypalenie zawodowe lekarzy. Medycyna Praktyczna 2019; 5: 121-124.
26. Kim H, Yeom H. The association between spiritual well-being and burnout in intensive care unit nurses: A descriptive study. Intensive Crit Care Nurs 2018; 46: 92-97. doi: 10.1016/j.iccn.2017.11.005.
27. Su A, Lief L, Berlin D, et al. Beyond pain: nurses' assessment of patient suffering, dignity, and dying in the intensive care unit. J Pain Symptom Manage 2018; 55: 1591-1598.e1. doi: 10.1016/j.jpainsymman.2018.02.005.
28. Swinton M, Giacomini M, Toledo F, et al. Experiences and expressions of spirituality at the end of life in the intensive care unit. Am J Respir Crit Care Med 2017; 195: 198-204. doi: 10.1164/rccm.201606-1102OC.
29. Cook D, Swinton M, Toledo F, et al. Personalizing death in the intensive care unit: the 3 Wishes Project: a mixed-methods study. Ann Intern Med 2015; 163: 271-279. doi: 10.7326/M15-0502.
30. Abuatiq A. Spiritual care for critical care patients. Int J Nurs Clin Pract 2015; 2: 128. http://dx.doi.org/10.15344/2394-4978/2015/128.
31. Yadak M, Ansari K, Qutub H, et al. The effect of listening to Holy Quran recitation on weaning patients receiving mechanical ventilation in the intensive care unit: a pilot study. Journal of Religion and Health 2019; 58: 64-73. doi: 10.1007/s10943-017-0500-3.
32. Gordon B, Keogh M, Davidson Z, et al. Addressing spirituality during critical illness: a review of current literature. J Crit Care 2018; 45: 76-81. doi: 10.1016/j.jcrc.2018.01.015.
33. Noome M, Beneken Genaamd Kolmer DM, van Leeuwen E, et al. The role of ICU nurses in the spiritual aspects of end-of-life care in the ICU: an explorative study. Scand J Caring Sci 2017; 31: 569-578. doi: 10.1111/scs.12371.

34. Maugans T. The SPIRITual history. Arch Fam Med 1996; 5: 11-16. doi: 10.1001/archfami.5.1.11.
35. Paal P, Frick E, Roser T, et al. Expert discussion on taking a spiritual history. J Palliat Care 2017; 32: 19-25.
36. Klimasiński M, Płocka M, Neumann-Klimasińska N, et al. Czy lekarze powinni udzielać wsparcia duchowego swoim pacjentom – przegląd badań. Med Prakt 2017; 3: 128-133.
37. Todres D, Catlin E, Thiel M. The intensivist in a spiritual care training program adapted for clinicians. Crit Care Med 2005; 33: 2733-2736. doi: 10.1097/01.ccm.0000189749.24916.40.
38. Bülow H, Sprung C, Reinhart K, et al. The world's major religions' points of view on end-of-life decisions in the intensive care unit. Intensive Care Med 2008; 34: 423-430. doi: 10.1007/s00134-007-0973-8.
39. Żołnierz J. Opieka duchowa w praktyce. Narzędzia do oceny duchowości pacjenta: HOPE, SPIRIT, CSI-MEMO, FAITH. In: Chodźko E, Szymczyk P (eds.). Wybrane prace z obszaru prawa, ekonomii i nauk społecznych. Wydawnictwo Naukowe Tygiel, Lublin 2018.
40. Żołnierz J. Opieka duchowa w praktyce. Narzędzia do oceny duchowości pacjenta: FICA, FACT. In: Chodźko E, Szymczyk P (eds.). Wybrane prace z obszaru prawa, ekonomii i nauk społecznych. Wydawnictwo Naukowe Tygiel, Lublin 2018.
41. Chochinov H. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. BMJ 2007; 335: 184-187. doi: 10.1136/bmj.39244.650926.47.
42. Sulmasy D. Spirituality, religion, and clinical care. Chest 2009; 135: 1634-1642. doi: 10.1378/chest.08-2241.
43. Ustawa z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta. Rozdział 10. Prawo pacjenta do opieki duszpasterskiej.
44. Krakowiak P, Janowicz A. Nowe propozycje opieki ze strony zespołowego duszpasterstwa służby zdrowia i pomocy społecznej. Piel Zdr Publ 2012; 2: 153-159.
45. Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. Am Fam Physician 2001; 63: 81-89.
46. Vandenhoeck A. Chaplains as specialists in spiritual care for patients in Europe. Pol Arch Med Wewn 2013; 123: 552-557.
47. Association of Professional Chaplains; Association for Clinical Pastoral Education; Canadian Association for Pastoral Practice and Education; National Association of Catholic Chaplains; National Association of Jewish Chaplains. A white paper. Professional chaplaincy: its role and importance in healthcare. J Pastoral Care 2001; 55: 81-97.
48. Johnson R, Wirpsa MJ, Boyken L, et al. Communicating chaplains' care: narrative documentation in a neuroscience-spine intensive care unit. J Health Care Chaplain 2016; 22: 133-150. doi: 10.1080/08854726.2016.1154717.
49. Timmins F, Naughton M, Plakas S, et al. Supporting patients' and families' religious and spiritual needs in ICU – can we do more? Nurs Crit Care 2015; 20: 115-117. doi: 10.1111/nicc.12177.
50. Cadge W, Freese J, Christakis N. The provision of hospital chaplaincy in the United States: a national overview. South Med J 2008; 101: 626-630. doi: 10.1097/SMJ.0b013e3181706856.
51. Brown D. The spiritual care of staff in an ITU. Health and Social Care Chaplaincy 2010; 13: 12-16.
52. Choi P, Curlin F, Cox C. "The patient is dying, please call the chaplain": the activities of chaplains in one medical center's intensive care units. J Pain Symptom Manage 2015; 50: 501-506. doi: 10.1016/j.jpainsymman.2015.05.003.
53. Teague P, Kraeuter S, York S, et al. The role of the chaplain as a patient navigator and advocate for patients in the intensive care unit: one academic medical center's experience. J Relig Health 2019; 58: 1833-1846. doi: 10.1007/s10943-019-00865-z.
54. Carey L, Cohen J. Chaplain-physician consultancy: when chaplains and doctors meet in the clinical context. J Relig Health 2009; 48: 353-367. doi: 10.1007/s10943-008-9206-x.
55. The Association of Professional Chaplains. Standards of practice in acute care settings. Available at: www.professionalchaplains.org/files/professional_standards/standards_of_practice/standards_practice_professional_chaplains_acute_care.pdf (Accessed: 03.05.2021).
56. Tartaglia A, Dodd-McCue D, Ford T, et al. Chaplain documentation and the electronic medical record: a survey of ACPE residency programs. J Health Care Chaplain 2016; 22: 41-53. doi: 10.1080/08854726.2015.1071544.
57. Massey K, Barnes MJ, Villines D, et al. What do I do? Developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care. BMC Palliat Care 2015; 14: 10. doi: 10.1186/s12904-015-0008-0.
58. Lee BM, Curlin FA, Choi PJ. Documenting presence: a descriptive study of chaplain notes in the intensive care unit. Palliat Support Care 2017; 15: 190-196. doi: 10.1017/S1478951516000407.
59. Ruth-Sahd L, Hauck C, Sahd-Brown K. Collaborating with hospital chaplains to meet the spiritual needs of critical care patients. Dimens Crit Care Nurs 2018; 37: 18-25. doi: 10.1097/DCC.0000000000000279.
60. Cook D, Rocker G. Dying with dignity in the intensive care unit. N Engl J Med 2014; 370: 2506-2514. doi: 10.1056/NEJMra1208795.
61. Jan Paweł II. List Apostolski Salvifici Doloris O Chrześcijańskim Sensie Ludzkiego Cierpienia. Available at: https://opoka.org.pl/biblioteka/W/WP/jan_pawel_ii/listy/salvifici.html (Accessed: 03.05.2021).
62. Katechizm Kościoła Katolickiego, kanon 1520. Praca zbiorowa. Available at: http://www.katechizm.opoka.org.pl/rkkkII-2-2.htm (Accessed: 03.05.2021).
63. Lee AC, McGinness CE, Levine S, O'Mahony S, Fitchett G. Using chaplains to facilitate advance care planning in medical practice. JAMA Intern Med 2018; 178: 708-710. doi: 10.1001/jamainternmed.2017.7961.
64. Timmins F, Caldeira S, Murphy M, et al. The role of the healthcare chaplain: a literature review. J Health Care Chaplain 2018; 24: 87-106. doi: 10.1080/08854726.2017.1338048.