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Invited Commentary

# Religion, Spirituality, and the Intensive Care Unit
## The Sound of Silence

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**Visualize for a moment** the philosophical quandary of a tree falling in the uninhabited forest and whether it makes a sound—the dying tree, its surroundings of fellow trees, foliage, and earth—with no person to hear its fall. This visualization hardly seems relevant to the intensive care unit (ICU), particularly because these seem to be manifestly opposing environments—one is quiet, organic, and verdant with life while the other is characterized by the sounds of human and technological activity, sterility, and illness. And yet the quandary posed by this visual exercise is central to the article by Ernecoff and colleagues[1] and to the question of the role of spirituality in caring for seriously ill patients and their families.

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In *The Rebirth of the Clinic*, Sulmasy calls illness a "spiritual event" that "grasps persons by the soul as by the body and disturbs both."[2(p17)] Certainly, data support Sulmasy's thesis,[3] with spirituality being important to most ill persons, contributing to coping and quality of life and being a source of spiritual needs. But what is meant by *spirituality*? Spirituality has been disputably and variably defined. According to the 2009 Spiritual Care Consensus Conference, "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred."[4(p887)] Religion, a related concept, is typically understood as a spirituality that is shared by a group of people, often with common beliefs and practices. Regardless of the varying definitions, what is clear is that spirituality is found in myriad forms, such as the sacredness of family, nature, or a relationship to the divine. Furthermore, what is also clear is that spirituality is typically out of place in medical environments, as foreign as the contrasting visuals of the lonely tree and bustling ICU. However, stranger still is the fact that, although we health care professionals struggle to connect spirituality and medicine as evidenced by the many and mounting articles that refute or explicate their connection, our patients and families typically do not struggle. For most, thoughts of what is most sacred, of what transcends the finitude of human life, come flooding in the moment the physician shares the news of the serious illness or the telephone call comes urging the listener to the bedside of a critically ill loved one.

The article by Ernecoff and colleagues[1] discusses with clarity and nuance the silence regarding spirituality in the setting of critical care. The study uses rigorous qualitative methods and is embedded in a prospective multisite study of family meetings at 13 ICUs across the United States. Using the audio recordings of 249 family meetings, the authors explore the religious and/or spiritual thematic content of goals-of-care conversations between health care professionals and surrogates of critically ill patients. Although religion was important to 77.6% of the surrogates, only 16.1% of the conferences included any reference to religion or spirituality. Furthermore, when they did occur, these conversations were initiated by surrogates 65.0% of the time. A health care professional raised spiritual concepts (eg, spiritual histories) only 14 times (5.6%), and only 2 of the conferences (0.8%) were attended by a chaplain. When surrogates raised spiritual concepts, health care professionals' most common response was to change the subject to the medical realities at hand. Although empathic responses were the next most common response, health care professionals, in general, "rarely directly addressed surrogate's spiritual or religious language." Only 2 health care professionals responded by exploring the patient's or surrogate's spirituality. Notably, for conversations that included religious and/or spiritual content, various themes were identified, with miracles being one of several spiritual themes that intersected with medical care.

The findings by Ernecoff and colleagues[1] regarding the silence surrounding religion and/or spirituality in ICU conversations are loud and clear. Still, there remain important unanswered questions. First, what definitions did the authors use to denote a religious or spiritual theme? Based on the quotes and the predominance of religious language used in their keyword search, their concept of religion and/or spirituality appears largely to be framed by what colloquially might be termed *religious*. Understanding the definition is critical to interpreting these frequencies and placing them in proper context, particularly because the de facto defi-



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nition may leave spiritual concepts unidentified. For example, would a surrogate's reference to an atheist loved one's preeminent value on control and autonomy be classified as a spiritual conversation? Although this is a contested subject, such values can be as sacred as a religious person's beliefs, for example, in God's sovereign control. Exclusion of certain sacredly held but nontraditional values could result in underrecognition of what are, to many, spiritual topics. However, what is clear from these data among a predominantly religious sample is that conversations using religious and/or spiritual language and concepts that are likely familiar to most (but not all) surrogates are infrequent.

Another unanswered question is the importance of including religion and/or spirituality in the family meeting of the 83.9% of surrogates for whom religion and/or spirituality were never discussed. Based on the importance of religion to most surrogates, it is unclear how many did not raise the subject of religion and/or spirituality because they preferred that these values were not discussed, did not find them relevant to the conversation, or did not feel the freedom to raise this topic, particularly given the medical team's lack of attention to these matters. Studies of seriously ill patients[5] indicate that many believe it is important and appropriate for health care professionals to attend to patient religious or spiritual concerns and values as part of medical care, suggesting that many more surrogates may have expressed these values if they had been raised by their health care professionals.

A third question raised by these findings concerns the potential effect of engaging religion and/or spirituality as part of a family meeting on patient and family medical outcomes. Although patient and family outcomes were not addressed by this study, other research[6] highlights the potential implications of providing spiritual care with medical care—for example, spiritual care's associations with greater ICU care satisfaction, better patient quality of life, and greater decisions for comfort-focused, end-of-life care.[7]

Finally, these data raise the question: If religion and/or spirituality were to be regularly discussed in family meetings, are health care professionals capable of integrating religion and/or spirituality into health care discussions? Can they, as Cook and Rocker[8] implore in their review, "pose questions about spiritual beliefs that may bear on experiences with respect to illness" as part of a larger goal of providing value-sensitive holistic care in the ICU? The qualitative information provided in the study by Ernecoff and colleagues[1] indicate that the answer to this question is frequently no and, as the authors highlight, indicate the crucial need for greater integration of chaplaincy into ICU care[4,6] and for spiritual care education for health care professionals,[5] including how to integrate a basic exploration of religious and/or spiritual values into health care communication.

Our patients and families who face serious illness typically find themselves in spiritual isolation in the medical setting; their medical caregivers do not hear the spiritual reverberations of illness on their well-being and medical decisions. As with the lonely, falling tree, the reverberations are undeniably there. The question remains whether we who care for dying persons and their families will learn how to be present and listen.

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