Spiritual Care in the ICU: Perspectives of Dutch Intensivists, ICU Nurses, and Spiritual Caregivers

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Abstract Since there are no scientific data available about the role of spiritual care (SC) in Dutch ICUs, the goal of this quantitative study was twofold: first, to map the role of SC as a part of daily adult ICU care in The Netherlands from the perspective of intensivists, ICU nurses, and spiritual caregivers and second, to identify similarities and differences among these three perspectives. This study is the quantitative part of a mixed methods approach. To conduct empirical quantitative cohort research, separate digital questionnaires were sent to three different participant groups in Dutch ICUs, namely intensivists, ICU nurses, and spiritual caregivers working in academic and general hospitals and one specialist oncology hospital. Overall, 487 participants of 85 hospitals (99 intensivists, 290 ICU nurses, and 98...
spiritual caregivers) responded. The majority of all respondents (>70%) considered the positive effects of SC provision to patients and relatives: contribution to mental well-being, processing and channeling of emotions, and increased patient and family satisfaction. The three disciplines diverged in their perceptions of how SC is currently evolving in terms of information, assessment, and provision. Nationwide, SC is not implemented in daily ICU care. The majority of respondents, however, attached great importance to interdisciplinary collaboration. In their view SC contributes positively to the well-being of patients and relatives in the ICU. Further qualitative research into how patients and relatives experience SC in the ICU is required in order to implement and standardize SC as a scientifically based integral part of daily ICU care.

Keywords Critical care · Intensive care · Spiritual care · Ethics · Existential and meaning of life issues · Quality of care · Quality of life

Introduction

Intensive care units (ICUs) are dominated by technical medical resources and equipment; the monitoring of vital functions has become the cornerstone of the healing process. Patients and relatives frequently feel abandoned in this technologically advanced environment. As soon as an ICU patient wakes up, feelings of being alone with their doubts, worries, or even agony easily arise. A common feature of ICU patients is that they are no longer able to communicate in the usual way due to their illness or treatment (sedation and intubation). Such a situation requires special communication skills, patience and intuition from relatives and caregivers (Willemse 2017). Critical illness challenges ICU patients and their relatives to find meaning and to deal with suffering. Their religious background or non-religious spiritual-existential beliefs are valuable coping tools for adaption and redefining hope (Adolph et al. 2011).

Since end-of-life care is an important part of ICU care, prior studies (M. J. Balboni et al. 2013, 2014; T. Balboni et al. 2011) into end-of-life care offer valuable data for research into SC in the ICU. However, SC is not limited to terminal care and is an essential component of basic patient rights (Kortner 2009). Therefore, it is important to investigate the way in which SC is integrated into daily ICU care. Spiritual issues are not frequently discussed between patients or their relatives and ICU staff. Moreover, ICU healthcare workers (HCW: intensivists and ICU nurses) often leave the spiritual needs of patients and/or their relatives to the in-house spiritual caregiver or the patient’s own parish clergy. They consider them better qualified than themselves to deal with problems of this kind because of time-consuming schedules or lack of experience. (M. J. Balboni et al. 2013; Ford et al. 2014).

When ICU staff offer SC to patients, the offer is generally appreciated. However, when they decide themselves to administer SC, then its effectiveness is less. (Hughes et al. 2007).

Our study aim was twofold: first, to map the role of SC as part of daily adult ICU care in the Netherlands from the perspective of intensivists, ICU nurses, and spiritual caregivers; and second, to identify the similarities and differences between the perspectives of these three disciplines. Differences in perspectives provide guidance on future qualitative research into patients and relatives’ experiences with SC in order to implement SC as an integral part of daily intensive care.
Methods

We used a mixed method to analyze separate questionnaires which were developed for intensivists, ICU nurses, and spiritual caregivers. Some questions were the same in all three questionnaires; others were specific to the discipline in question. The questionnaires consisted of 40 questions covering the following categories: (1) spiritual care provision; (2) HCW competency and time investment; (3) communication and interventions in the context of interdisciplinary cooperation; (4) SC effects, support, and implementation at the policy level. The design of the questionnaires was based on the intensivist’s (NF) and the spiritual caregiver’s (SW) personal work experience in the ICU as well as previous international research (Festic et al. 2012). The questionnaires were reviewed by various professionals, including methodologists, intensivists, ICU nurses, and spiritual caregivers. The digital questionnaires were sent to all ICUs in the Netherlands and were completed anonymously between May and October 2013. Only the type of hospital (university, teaching, or neither) and the regional distribution (rural or urban) could be traced. Reminders were sent and, if necessary, an additional request to complete the questionnaire was made by phone and mail, with the goal of having at least one fully completed questionnaire per discipline per hospital.

Questionnaire responses were analyzed using SPSS Statistics. Results were considered statistically significant when \( p < 0.05 \). Descriptive statistics and Chi-square tests were used to compare responses among groups. First of all, omnibus Chi-square tests were used to compare responses; those that differ significantly among any of the groups are highlighted in the tables (bold print). Secondly, in case of particularly important or notable findings, we performed additional Chi-square tests for between group comparisons, which are mentioned in the text of the result section.

 Percentages presented in the text and tables sometimes exceed 100% because multiple answers were permitted for most questionnaire items. Not all answers are presented in the tables for the sake of brevity.

The study was performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments (WMA 2013). As no patients were involved and all participants contributed anonymously, informed consent was waived by the ethical review board.

Results

Ninety-two hospitals were approached to participate in the study, with an overall response rate of 92% (85 participating hospitals). Seven hospitals refrained from participating for the following reasons: no in-house spiritual care service (4), no in-house ICU (1), objections in principle (1), and long-term absence of a spiritual caregiver (1). The 85 participating hospitals could be classified as follows: 8 university hospitals, 44 teaching hospitals (including one specialized cancer center), and 33 non-teaching hospitals.

Together, the 85 hospitals yielded 487 respondents. In terms of disciplines, 99 intensivists, 290 ICU nurses, and 98 spiritual caregivers participated from 66 hospitals (78%), 77 hospitals (91%), and 79 hospitals (93%), respectively (Table 1).

The item response rate was high: 95% of the substantive questions were answered by 92% of the intensivists, 95% of the ICU nurses, and 92% of the spiritual caregivers.
In 92% of all participating hospitals, a spiritual caregiver provided SC support in the ICU. More than 80% of all respondents considered patients’ philosophy of life and their spiritual background important or very important in how they cope with their illness. It should be mentioned that the respondents were free to define “philosophy of life/spirituality” as they wished.

The results showed that 13% of the intensivists and 12% of the ICU nurses indicated that patients and/or their relatives had shared with them their philosophy of life regarding spirituality “at least most of the time.” In contrast, 76% of the spiritual caregivers indicated that patients talked about this topic with them ($p < 0.001$).

Patients and their relatives were informed about the availability of SC in more than one way. Their awareness of this availability was largely attained through the ICU nurses and by means of a brochure. Still, the respondents estimated that 10% of all ICU patients and/or relatives were not offered any information about the possibility of SC. Significant differences were noted between the three disciplines in terms of their provision of information. Provision of information about the availability of SC to patients and/or relatives by intensivists was twice as high according to intensivists themselves (35%) than according to ICU nurses (15%) and spiritual caregivers (16%) ($p < 0.001$). There was a significant

| Table 1 | Participant characteristics |
|---------|-----------------------------|
| Characteristics | All respondents ($n = 487$) N% | Intensivists ($n = 99$) N% | ICU nurses ($n = 290$) N% | Spiritual caregivers ($n = 98$) N% |
| Gender | | | | |
| Male | 204 (41.9) | 64 (64.6) | 85 (29.3) | 55 (56.1) |
| Female | 280 (57.5) | 35 (35.4) | 203 (70.0) | 42 (42.9) |
| Missing | 3 (0.6) | – | 2 (0.7) | 1 (1.0) |
| Age (years) | | | | |
| Mean (SD) | 46.1 (9.6) | 44.8 (7.0) | 43.9 (9.6) | 53.6 (7.6) |
| Missing | 2 | 1 | 1 | 2 |
| Years of experience | | | | |
| 0–3 years | 46 (9.4) | 10 (10.1) | 25 (8.6) | 11 (11.2) |
| 3–10 years | 139 (28.5) | 52 (52.5) | 70 (24.1) | 17 (17.3) |
| >10 years | 299 (61.4) | 37 (37.4) | 194 (66.9) | 68 (69.4) |
| Missing | 3 (0.6) | – | 1 (0.3) | 2 (2.0) |
| Work setting | | | | |
| Academic hospital | 77 (15.8) | 19 (19.2) | 49 (16.9) | 9 (9.2) |
| Community-based teaching hospital | 196 (40.3) | 38 (38.4) | 119 (41.0) | 39 (39.8) |
| Other teaching hospital | 69 (14.2) | 19 (19.2) | 31 (10.7) | 20 (20.4) |
| Non-teaching hospital | 142 (29.2) | 23 (23.2) | 89 (30.7) | 30 (30.6) |
| Missing | 2 (0.4) | – | 2 (0.7) | – |
| Number of hospitals | 85 (92.3) | 66 (77.6) | 77 (90.5) | 79 (93.0) |

**Spiritual Care Provision**

In 92% of all participating hospitals, a spiritual caregiver provided SC support in the ICU. More than 80% of all respondents considered patients’ philosophy of life and their spiritual background important or very important in how they cope with their illness. It should be mentioned that the respondents were free to define “philosophy of life/spirituality” as they wished.

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difference in the perception of responsibility for calling the spiritual caregiver after notifying the patient of the availability of SC. Intensivists surmised that they were responsible in 71% of cases; however, ICU nurses thought that intensivists were responsible in only 41% of all cases ($p < 0.001$). The intensivists’ and ICU nurses’ estimates of involving a spiritual caregiver at the intensivists’ request through an ICU nurse differed considerably: 68 versus 24%, $p < 0.001$, Table 2). Furthermore, one out of three respondents reported that SC was provided through the spiritual caregiver’s initiative only.

Table 2 shows that HCW most often consult a spiritual caregiver through an oral request and less than 7% of HCW made a written request for SC despite legislation requiring documentation of all aspects of health care delivered to patients. ICU nurses reported more frequently making requests by telephone compared to intensivists (45% vs 19%, $P < 0.001$, Table 2). According to 94% of all respondents, involvement of the spiritual caregiver takes place “at the patient’s request.”

All respondents took care of active requests for SC from patients and/or relatives, in particular questions regarding the meaning of illness and existence. These questions are the most important indicators for consulting a spiritual caregiver. Intensivists and ICU nurses considered dealing with these ethical questions in relation to an ICU patient an important part of the spiritual caregiver’s job (77 and 85%, respectively). Ninety percent of HCW indicated that in the case of questions regarding the meaning of illness and existence their professional actions are important or very important. (Table 2). However, 15% of the intensivists and 27% of the ICU nurses indicated that these questions were “never” asked in the month prior to completing the questionnaire ($p < 0.001$). According to the majority of HCW (78%), patients and relatives declined the offer of spiritual care primarily because they had “no need for spiritual care,” while according to the majority of spiritual caregivers (81%), “insufficient knowledge of spiritual care availability” was the reason for declining the offer. Not only patients and their relatives have access to SC. HCW can ask for SC for themselves in case of emotional distress. One-third of intensivists (29%) and ICU nurses (36%) felt it was important to be able to rely on a spiritual caregiver for themselves after the death of a particular patient. The results show that 16% of HCW consider collegial support given by the spiritual caregiver to ICU staff as part of SC provision. In contrast, 49% of the spiritual caregivers consider collegial support to ICU staff as one of their tasks ($p < 0.001$).

**HCW Competency and Time Investment**

Table 3 provides an overview of HCW competency and time investment related to patients’ spiritual needs. As can be seen, 66% of HCW consider themselves capable of discussing existential questions and the meaning of illness. However, 90% of HCW indicated that the spiritual caregiver was the most appropriate professional to explore patients’ needs for SC.

The extent to which intensivists thought that they had to answer existential questions (71%) and the extent to which ICU nurses indicated that intensivists should answer these questions (48%) differed significantly ($p < 0.001$). More than 74% of the intensivists and ICU nurses thought that they would need 20–30 min to discuss existential questions. Reasons given for having insufficient time to explore these questions were reported as “too many other tasks” (61% of intensivists), “patient complexity” (76% of ICU nurses), and too few permanent positions” (24% of spiritual caregivers). In general, spiritual caregivers answered calls within 1–2 h, with an average of 3 consultations at a mean duration of 15–30 min each. According to all three disciplines, SC primarily takes shape by
conducting talks, as well as through presence with patient and/or relatives and working with rituals. Spiritual caregiver involvement at HCW request in explicit situations like withdrawal of treatment, problems in the relations between patient and relatives, and organ donation was not rated as highly by spiritual caregivers as it was by HCW (Table 3).

| Table 2  | Spiritual care provision |
|----------|--------------------------|
| Spiritual care provision | All respondents (n = 487) N% | Intensivists (n = 99) N% | ICU nurses (n = 290) N% | Spiritual caregivers (n = 98) N% | p/ pr |
| The role of the philosophy of life/spirituality of the patient in the way the patient copes with his/her illness (scores ≥ 4)* | 423 (86.8) | 81 (81.8) | 254 (87.5) | 88 (89.7) | p |
| Provision information SC by intensivists | 95 (19.5) | 35 (35) | 44 (15) | 16 (16) | pr |
| SC called at intensivist’s request | 256 (52.6) | 71 (71) | 118 (40.7) | 67 (68) | pr |
| SC called at intensivist’s request through ICU nurse | 137 (35.2) | 67 (67.7) | 70 (24.1) | N/A | pr |
| Not offered information on spiritual care | 62 (12.7) | 13 (13.1) | 40 (13.8) | 9 (9.2) | pr |
| Own initiative spiritual caregiver | 182 (37.4) | 27 (27.3) | 110 (37.9) | 45 (45.9) | pr |
| Oral request for SC | 295 (75.8) | 65 (66) | 230 (79) | N/A | pr |
| Telephone request for SC | 150 (38.6) | 19 (19) | 131 (45) | N/A | pr |
| Written request for SC | 24 (6.2) | 4 (4) | 20 (7) | N/A | pr |

**Important indicators for HCW to consult a spiritual caregiver (scores ≥ 4)*

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| Questions regarding the meaning of illness and existence* | 352 (90.4) | 89 (89.9) | 263 (90.7) | N/A | pr |
| Lack of community support* | 311 (79.9) | 75 (76.5) | 236 (83.1) | N/A | pr |
| Problems with a certain image of God* | 290 (74.6) | 72 (72.7) | 218 (75.1) | N/A | pr |
| Ethical questions concerning withdrawing treatment* | 256 (65.8) | 57 (57.6) | 199 (68.6) | N/A | pr |
| Problems with religious customs* | 237 (62.4) | 60 (60.6) | 177 (70) | N/A | pr |
| Despondency* | 223 (57.3) | 49 (49.5) | 174 (60) | N/A | pr |
| Problems with rituals* | 207 (53.2) | 47 (47.5) | 160 (55.2) | N/A | pr |

**Important actions (scores ≥ 4)* by HCW in case of questions regarding the meaning of illness and existence of patients

| Important actions (scores ≥ 4)* by HCW in case of questions regarding the meaning of illness and existence of patients |
| Identify questions regarding the meaning of illness and existence* | 354 (91.0) | 92 (92.9) | 262 (90.3) | N/A | p |
| Explore these questions* | 345 (88.7) | 86 (86.9) | 259 (89.3) | N/A | p |
| Guide the patient* | 310 (79.7) | 71 (71.7) | 239 (82.4) | N/A | p |
| Refer the patient to other professionals* | 365 (93.8) | 87 (87.9) | 278 (95.9) | N/A | p |
| Never signaled an existential question in the last month | 99 (20.3) | 15 (15.2) | 77 (26.6) | 7 (7.1) | pr |
| Signaled only one existential question in the last month | 90 (18.5) | 11 (11.1) | 74 (25.5) | 5 (5.1) | pr |
| Patient’s sharing of philosophy of life/spirituality at least most of the time | 122 (25) | 13 (13.1) | 35 (12.1) | 74 (75.5) | pr |

* 5-point Likert scale: 1 = very unimportant, 2 = not important, 3 = neutral, 4 = important, 5 = very important

p SC referring to patient, pr SC referring to patient and/or relatives, HCW healthcare workers responses in bold print indicate a significant difference (p < 0.05) among the respondent groups
Communication and Interventions in the Context of Interdisciplinary Cooperation

Table 4 shows that SC provided by a spiritual caregiver is not yet embedded in daily ICU care. Forty-six percent of HCW indicated that cooperation with the spiritual caregiver took place on demand. The intensivists indicated that spiritual caregivers participated in ethical considerations twice as often as in multidisciplinary rounds (MDRs). Spiritual caregivers mainly reported their findings in a patient file. They reported orally to ICU nurses twice as often as to intensivists. Spiritual caregivers refrained sometimes (11%) from reporting for reasons of confidentiality.

All three disciplines attached great importance to interdisciplinary collaboration and regarded it as an important condition for spiritual caregiver intervention. In addition, according to the respondents, the following conditions in particular are necessary for integrated cooperation with the spiritual caregiver: (1) sufficient knowledge of SC provision among the various disciplines working in the ICU, (2) HCW’s attention to indicators of spiritual needs, and (3) binding agreements with respect to SC in accordance with protocols (Table 4).
Since there is no validated instrument to measure the effects of spiritual care in ICUs, all three disciplines were asked to answer questions about their experiences concerning these effects on patients and their relatives. The effects of SC in the ICU were usually positively experienced by 70% of all three disciplines. Table 4 shows that those effects were (1) positive contribution to mental well-being, (2) processing and channeling emotions, and (3) increased patient and family satisfaction. The table also shows the phenomena encountered when SC is provided (scores ≥ 4):

- Despair as a result of not being in control
- Vain search for hope and perspective
- Questions about making choices regarding treatment in the light of moral conviction

Insufficient knowledge of SC provision and HCW attention to indicators of spiritual needs were also noted. Conditions for interdisciplinary collaboration include sufficient knowledge of SC provision, HCW attention to indicators of spiritual needs, and protocol for SC. The boards of the participating hospitals were noted to support and implement SC at the policy level.

 Responses in bold print indicate a significant difference (p < 0.05) among the respondent groups.

**Table 4 Interdisciplinary collaboration: SC effects, support, and implementation at the policy level**

| Interdisciplinary collaboration | All respondents (n = 487) | Intensivists (n = 99) | ICU nurses (n = 290) | Spiritual caregivers (n = 98) |
|-------------------------------|---------------------------|----------------------|----------------------|-----------------------------|
| SC effects, support, and implementation of SC at the policy level | N% | N% | N% | N% |
| On demand                     | 225 (46.2)                | 45 (45.5)            | 139 (47.9)           | 41 (41.8)                   |
| SC implemented in multidisciplinary care | 99 (20.3)                | 22 (22.2)            | 42 (14.5)            | 35 (35.7)                   |
| No interdisciplinary collaboration yet | 60 (12.3)                | 16 (16.2)            | 41 (14.1)            | 3 (3.1)                     |
| Participation of the spiritual caregiver in structural forms | | | | |
| No consultation forms | 256 (52.5)                | 43 (43.4)            | 159 (54.8)           | 54 (55.1)                   |
| Ethical considerations      | 161 (33)                  | 44 (44.4)            | 85 (29.3)            | 32 (32.7)                   |
| MDRs (multidisciplinary rounds) | 92 (18.8)                | 20 (20.2)            | 47 (16.2)            | 25 (25.5)                   |
| Team meetings               | 29 (5.9)                  | 10 (10.1)            | 15 (5.2)             | 4 (4.1)                     |
| Conditions for interdisciplinary collaboration | | | | |
| Sufficient knowledge of SC provision | 371 (76.1)                | 82 (82.8)            | 202 (69.7)           | 87 (88.8)                   |
| HCW attention to indicators of spiritual needs | 360 (73.9)                | 73 (73.7)            | 195 (67.2)           | 92 (93.9)                   |
| Protocol for SC             | 328 (67.3)                | 58 (58.6)            | 193 (66.6)           | 76 (77.6)                   |
| Transparent approach of spiritual caregiver | 281 (57.7)                | 49 (49.5)            | 154 (53.1)           | 78 (79.6)                   |
| MDRs (multidisciplinary rounds) | 197 (40.4)                | 32 (32.3)            | 107 (36.9)           | 58 (59.2)                   |
| Attention to HCW’s emotional problems | 182 (37.3)                | 31 (31.3)            | 93 (32.1)            | 58 (59.2)                   |
| Anchoring SC at the policy level | 169 (34.7)                | 25 (25.3)            | 70 (24.1)            | 74 (75.5)                   |
| SC effects (scores ≥ 4)*    | 355 (72.8)                | 66 (66.7)            | 203 (70)             | 86 (87.8)                   |
| Positive contribution to mental well-being | 328 (67.3)                | 66 (66.7)            | 188 (64.8)           | 74 (75.5)                   |
| Processing and channeling emotions | 326 (66.9)                | 61 (61.7)            | 195 (67.3)           | 70 (71.5)                   |
| Increased patient and family satisfaction | 325 (66.7)                | 72 (72.7)            | 176 (60.7)           | 77 (78.6)                   |
| The boards of the participating hospitals | 372 (76.3)                | 74 (74.7)            | 211 (72.8)           | 87 (88.8)                   |

* 5-point Likert Scale: 1 = never, 2 = usually not, 3 = sometimes, 4 = usually, 5 = always

**SC Effects, Support, and Implementation at the Policy Level**

Since there is no validated instrument to measure the effects of spiritual care in ICUs, all three disciplines were asked to answer questions about their experiences concerning these effects on patients and their relatives. The effects of SC in the ICU were usually positively experienced by >70% of all three disciplines. Table 4 shows that those effects were (1) positive contribution to mental well-being, (2) processing and channeling emotions, and (3) increased patient and family satisfaction. The table also shows the phenomena encountered when SC is provided (scores ≥ 4).
with the patient and the patient’s relatives when spiritual care is provided, during or after SC provision.

A majority of all respondents believed that ICU management supported SC, which might have been reflected in the ICU policy documentation. Respondents showed high scores (>72%) in terms of SC support on the boards of the participating hospitals at the policy level. (Table 4).

**Discussion**

This study’s aim was to map the role of SC as part of daily ICU care in Dutch adult ICUs from the perspective of intensivists, ICU nurses, and spiritual caregivers. Furthermore, data were collected to identify the similarities and differences among those three perspectives. According to the majority of respondents from all three perspectives, patients and their relatives benefit from SC with respect to quality of care and quality of life. This finding corresponds to the results of previous international studies (Gries et al. 2008, 2010; Johnson et al. 2014; Kirchhoff & Faas 2007; Kirchhoff et al. 2008; Rosik & Soria 2012; Wall et al. 2007). How patients and relatives experience SC in the ICU is an important target for further qualitative research (Kross et al. 2009; Wahlin et al. 2009). Moreover, the vast majority of respondents considered the patient’s philosophy of life and spirituality most important in how he/she copes with illness. These results match those observed in an earlier study (Delgado-Guay et al. 2011).

In agreement with past research, the majority of Dutch HCW think that the spiritual caregiver is the primary professional to explore questions of existential meaning and ethical issues (Curtis & Vincent 2010; Jensen et al. 2013).

Although almost all Dutch ICUs have at least one spiritual caregiver, hardly any of these ICUs have standardized SC methods to incorporate the assessments of the spiritual needs of patients and/or their relatives in the ICU. Earlier studies confirm the importance of such standardization (Benito et al. 2014; Hughes et al. 2007; Smeets et al. 2011). Regarding SC information, assessment, and provision, the results show significant differences among the perspectives of intensivists, ICU nurses, and spiritual caregivers. In relation to SC provision, a discrepancy emerged between intensivists’ and ICU nurses’ views of when they take the initiative to call in the spiritual caregiver. ICU nurses spend much more time with the ICU patients than intensivists, and probably feel more involved with the patient. This might explain the differences observed. In concordance, the frequency of spiritual caregivers reporting to ICU nurses after visiting the patient and/or relatives is twice as high as for intensivists (James et al. 2011; Lundberg & Kerdonfag 2010).

Could it be that intensivists are not always aware of ICU nurses’ taking the initiative to involve a spiritual caregiver, or that spiritual caregivers feel more comfortable reporting to ICU nurses? This observation calls for improvement of internal communication among ICU staff and is in accordance with documented differences among HCW in an earlier study regarding spiritual assessment in end-of-life care (Festic et al. 2012; Schenker et al. 2012). Other studies similarly show the importance of signaling the need for SC support for patients and relatives (Ho et al. 2011; Penrod et al. 2012).

The current study shows that in cases in which SC is offered by the HCW or spiritual caregiver and subsequently declined, patients and relatives decline the offer of SC primarily because of having “no need for SC.” Spiritual caregivers consider “insufficient
knowledge of SC availability” the main reason for declining that offer. Education of HCW by spiritual caregivers could contribute to the improvement of communication concerning SC provision (Ford et al. 2014; Gordon et al. 2012; Puchalski et al. 2014; Schaefer & Block 2009). Moreover, most HCW are not aware of how SC can contribute to their own mental well-being (Guthrie 2014; Poncet et al. 2007; St Ledger et al. 2013; Wahlin et al. 2010). This may explain the significant difference between the response of spiritual caregivers and the HCW in relation to collegial support by the spiritual caregiver to ICU staff. The majority of respondents regarded multidisciplinary cooperation in the ICU as important. International studies confirm the importance of integrated SC in the ICU (Cook & Rocker 2014; Handzo et al. 2014; Ho et al. 2011; Hughes et al. 2007; Loscalzo 2008; Truog et al. 2008). The current study shows that all HCW regard sufficient knowledge of SC provision and attention to signaling of patients’ spiritual needs as important conditions for inter-disciplinary collaboration. Moreover, only one out of three spiritual caregivers stated that SC was implemented in multidisciplinary care. Apparently, spiritual care is not an integral part of daily intensive care in Dutch ICUs. This may explain the significant differences reflected in Table 4.

The majority of respondents indicated that they had enough time to explore questions regarding the meaning of illness and existence. However, in the case of insufficient time, “too many other tasks” and “patient complexity” were the main barriers mentioned. Barriers HCW encountered in relation to SC support mentioned in earlier studies are “insufficient time” and “insufficient education” (M. J. Balboni et al. 2014; Gordon et al. 2012; Ronaldson et al. 2012). All these barriers have important implications for the development of the role of SC in the ICU.

As concluded in previous studies, it is recommended that spiritual caregivers provide evidence-based SC to improve the quality of care, following the example set by physicians who routinely provide evidence-based care (Curtis & White 2008; Fitchett 2011; Fitchett et al. 2014; Handzo et al. 2014; Kalish 2012). It is encouraging that a vast majority of spiritual caregivers have a positive attitude toward examining patient, family, and ICU staff satisfaction (Fitchett et al. 2014; Handzo et al. 2014).

Finally, according to three-quarters of the respondents, the boards of the participating hospitals supported SC at policy level. To secure this support, further scientific research into SC in hospitals is of vital importance.

We are aware that the results of our study are susceptible to selection bias, especially as the number of responding intensivists and ICU nurses was a relatively low fraction of all HCW in the ICUs. However, every respondent was asked to complete the questionnaire in light of daily ICU practice as much as possible and not only based on personal experience/opinions. Since 85 out of 92 hospitals participated, we think this study gives a representative overview of SC in ICUs in the Netherlands, despite the aforementioned restriction.

**Conclusions**

This study shows that SC is not yet an integrated part of daily ICU care at a national level, despite the finding that the majority of intensivists, ICU nurses, and spiritual caregivers think SC contributes positively to the well-being of patients and relatives in the ICU.

Additional findings included other similarities, but also differences in experiences with SC in the ICU from the perspectives of health care workers (HCW: intensivists and ICU nurses) and spiritual caregivers, and barriers that both HCW and spiritual caregivers
encounter in ICU care. Moreover, this study points toward improvement of internal communication and interdisciplinary collaboration, expansion of knowledge of SC provision, and provision of evidence-based SC practice.

Our findings call for the second part of the mixed methods approach, namely qualitative research into the experiences of patients and their relatives in relation to SC in the ICU.

Since the mixed methods approach compares, validates, and corroborates the data of quantitative and qualitative research, it will give an insight into how the implementation and subsequent improvement of SC in daily ICU care can be realized, with the aim of improving quality of life for ICU patients and their relatives.

Compliance with Ethical Standard

Conflict of interest The authors declare that they have no conflicts of interest.

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References

Adolph, M. D., Frier, K. A., Stawicki, S. P., Gerlach, A. T., & Papadimos, T. J. (2011). Palliative critical care in the intensive care unit: A 2011 perspective. International Journal of Critical Illness and Injury Science, 1(2), 147–153. doi:10.4103/2229-5151.84803.

Balboni, T., Balboni, M., Paulk, M. E., Phelps, A., Wright, A., Peteet, J., et al. (2011). Support of cancer patients’ spiritual needs and associations with medical care costs at the end of life. Cancer, 117(23), 5383–5391. doi:10.1002/cncr.26221.

Balboni, M. J., Sullivan, A., Amobi, A., Phelps, A. C., Gorman, D. P., Zollfrank, A., et al. (2013). Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. Journal of Clinical Oncology, 31(4), 461–467. doi:10.1200/JCO.2012.44.6443.

Balboni, M. J., Sullivan, A., Enzinger, A. C., Epstein-Peterson, Z. D., Tseng, Y. D., Mitchell, C., et al. (2014). Nurse and physician barriers to spiritual care provision at the end of life. Journal of Pain and Symptom Management, 48(3), 400–410. doi:10.1016/j.jpainsymman.2013.09.020.

Benito, E., Oliver, A., Galiana, L., Barreto, P., Pascual, A., Gomis, C., et al. (2014). Development and validation of a new tool for the assessment and spiritual care of palliative care patients. Journal of Pain and Symptom Management, 47(6), 1008–1018. doi:10.1016/j.jpainsymman.2013.06.018.

Cook, D., & Rocker, G. (2014). Dying with dignity in the intensive care unit. New England Journal of Medicine, 370(26), 2506–2514. doi:10.1056/NEJMra1208795.

Curtis, J. R., & Vincent, J. L. (2010). Ethics and end-of-life care for adults in the intensive care unit. Lancet, 376(9749), 1347–1353. doi:10.1016/S0140-6736(10)60143-2.

Curtis, J. R., & White, D. B. (2008). Practical guidance for evidence-based ICU family conferences. Chest, 134(4), 835–843. doi:10.1378/chest.08-0235.

Delgado-Guay, M. O., Hui, D., Parsons, H. A., Govan, K., De la Cruz, M., Thorney, S., et al. (2011). Spirituality, religiosity, and spiritual pain in advanced cancer patients. Journal of Pain and Symptom Management, 41(6), 986–994. doi:10.1016/j.jpainsymman.2010.09.017.

Feste, E., Wilson, M. E., Gajic, O., Divertie, G. D., & Rabatin, J. T. (2012). Perspectives of physicians and nurses regarding end-of-life care in the intensive care unit. Journal of Intensive Care Medicine, 27(1), 45–54. doi:10.1177/0885066610393465.

Fitchett, G. (2011). Making our case(s). Journal of Health Care Chaplain, 17(1–2), 3–18. doi:10.1080/08854726.2011.559829.

Fitchett, G., Nieuwsma, J. A., Bates, M. J., Rhodes, J. E., & Meador, K. G. (2014). Evidence-based chaplaincy care: attitudes and practices in diverse healthcare chaplain samples. Journal of Health Care Chaplaincy, 20(4), 144–160. doi:10.1080/08854726.2014.949163.
Ford, D. W., Downey, L., Engelberg, R., Back, A. L., & Curtis, J. R. (2014). Association between physician trainee self-assessments in discussing religion and spirituality and their patients’ reports. *Journal of Palliative Medicine, 17*(4), 453–462. doi:10.1089/jpm.2013.0388.

Gordon, E., Ridley, B., Boston, J., & Dahl, E. (2012). The building bridges initiative: learning with, from and about to create an interprofessional end-of-life program. *Dynamics, 23*(4), 37–41.

Gries, C. J., Curtis, J. R., Wall, R. J., & Engelberg, R. A. (2008). Family member satisfaction with end-of-life decision making in the ICU. *Chest, 133*(3), 704–712. doi:10.1378/chest.07-1773.

Gries, C. J., Engelberg, R. A., Kross, E. K., Zatzick, D., Nielsen, E. L., Downey, L., et al. (2010). Predictors of symptoms of posttraumatic stress and depression in family members after patient death in the ICU. *Chest, 137*(2), 280–287. doi:10.1378/chest.09-1291.

Guthrie, M. (2014). A health care chaplain’s pastoral response to moral distress. *Journal of Health Care Chaplaincy, 20*(1), 3–15. doi:10.1080/08854726.2014.867684.

Handzo, G. F., Cobb, M., Holmes, C., Kelly, E., & Sinclair, S. (2014). Outcomes for professional health care chaplaincy: an international call to action. *Journal of Health Care Chaplaincy, 20*(2), 43–53. doi:10.1080/08854726.2014.902713.

Ho, L. A., Engelberg, R. A., Curtis, J. R., Nelson, J., Luce, J., Ray, D. E., et al. (2011). Comparing clinician ratings of the quality of palliative care in the intensive care unit. *Critical Care Medicine, 39*(5), 975–983. doi:10.1097/CCM.0b013e3182091db.

Hughes, B., Whitmer, M., & Hurst, S. (2007). Innovative solutions: a plurality of vision–integrating the chaplain into the critical care unit. *Dimensions Critical Care Nursing, 26*(3), 91–95. doi:10.1097/01.DCC.0000267801.62949.6d.

James, J., Cottle, E., & Hodge, R. D. (2011). Registered nurse and health care chaplains experiences of providing the family support person role during family witnessed resuscitation. *Intensive & Critical Care Nursing, 27*(1), 19–26. doi:10.1016/j.iccn.2010.09.001.

Jensen, H. I., Ammentorp, J., Johannessen, H., & Ording, H. (2013). Challenges in end-of-life decisions in the intensive care unit: an ethical perspective. *Journal of Bioethical Inquiry, 10*(1), 93–101. doi:10.1007/s11673-012-9416-5.

Johnson, J. R., Engelberg, R. A., Nielsen, E. L., Kross, E. K., Smith, N. L., Hanada, J. C., et al. (2014). The association of spiritual care providers’ activities with family members’ satisfaction with care after a death in the ICU. *Critical Care Medicine, 42*(9), 1991–2000. doi:10.1097/CCM.0000000000000412.

Kalish, N. (2012). Evidence-based spiritual care: a literature review. *Current Opinion Supportive Palliative Care, 5*(4), 453–462. doi:10.1089/jpm.2013.0388.

Kortner, U. H. (2009). Spirituality, religion and culture on the intensive care unit–how are these compatible? *Journal of Trauma Dissociation, 13*(1), 69–87. doi:10.1080/15299732.2011.606739.
Schaefer, K. G., & Block, S. D. (2009). Physician communication with families in the ICU: evidence-based strategies for improvement. *Current Opinion Critical Care, 15*(6), 569–577. doi:10.1097/MCC.0b013e328332f524.

Schenker, Y., Crowley-Matoka, M., Dohan, D., Tiver, G. A., Arnold, R. M., & White, D. B. (2012). I don’t want to be the one saying ‘we should just let him die’: intrapersonal tensions experienced by surrogate decision makers in the ICU. *Journal of General Internal Medicine, 27*(12), 1657–1665. doi:10.1007/s11606-012-2129-y.

Smeets, W., Gribnau, F., & van der Ven, J. (2011). Quality assurance and spiritual care. *Journal of Empirical Theology, 24*, 80–121.

St Ledger, U., Begley, A., Reid, J., Prior, L., McAuley, D., & Blackwood, B. (2013). Moral distress in end-of-life care in the intensive care unit. *Journal of Advanced Nursing, 69*(8), 1869–1880. doi:10.1111/jan.12053.

Truog, R. D., Campbell, M. L., Curtis, J. R., Haas, C. E., Luce, J. M., & Rubenfeld, G. D. (2008). Recommendations for end-of-life care in the intensive care unit: a consensus statement by the American college of critical care medicine. *Critical Care Medicine, 36*(3), 953–963. doi:10.1097/CCM.0B013E3181659096.

Wahlin, I., Ek, A. C., & Idvall, E. (2009). Empowerment in intensive care: patient experiences compared to next of kin and staff beliefs. *Intensive & Critical Care Nursing, 25*(6), 332–340. doi:10.1016/j.iccn.2009.06.003.

Wahlin, I., Ek, A. C., & Idvall, E. (2010). Staff empowerment in intensive care: nurses’ and physicians’ lived experiences. *Intensive & Critical Care Nursing, 26*(5), 262–269. doi:10.1016/j.iccn.2010.06.005.

Wall, R. J., Engelberg, R. A., Gries, C. J., Glavan, B., & Curtis, J. R. (2007). Spiritual care of families in the intensive care unit. *Critical Care Medicine, 35*(4), 1084–1090. doi:10.1097/01.ccm.0000259382.36414.06.

Willemse, S. J., Smeets, W., van Leeuwen, E., & Foudraine, N. (2017). Spiritual care in the intensive care unit: an integral part of daily intensive care? *Netherlands Journal of Critical Care, 25*(2), 62–65.

World Medical Association (WMA) (2013). Declaration of Helsinki—ethical principles for medical research involving human subjects. Available from https://www.wma.net/en/30publications/10policies/b3/.