Canadian Oncology Nursing Journal

Revue canadienne de soins infirmiers en oncologie

Volume 31, Issue 3 • Summer 2021
eISSN: 2368-8076

CANO ACIO
Canadian Association of Nurses in Oncology
Association canadienne des infirmières en oncologie

BRIEF COMMUNICATION

Call to action: The need to expand spiritual care supports during the COVID-19 pandemic

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ABSTRACT

Providing a 'good death' for patients dying in acute care is more challenging than ever with the COVID-19 pandemic. Spiritual care teams and palliative care providers strive to address the physical, psychosocial, and spiritual care needs at end of life—for both patients and their families, and often in concert with patients' own faith groups. During the strict lockdown policy imposed in Ontario, Canada during the pandemic, external faith groups, and religious rituals requiring direct contact were restricted. Delivering spiritual care in our "new normal" environment challenged us to think more broadly, beyond the walls of our own institutions, particularly when external resources exist outside of acute care centres, and are often of paramount importance to dying patients and their families in acute care.

AUTHOR NOTES

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Acknowledgement: Rev. Fr. Haridimos Sarris and RC Priest Fr. Pheal Bussiere for their contribution in explaining the Christian rituals.

Key words: pandemic, COVID-19, palliative care, spiritual care, end of life

Despite best efforts to provide a 'good death' for patients dying in hospital, gaps still exist in the delivery of end-of-life (EOL) care in the acute care setting (Bender et al., 2017). Providing an inclusive EOL experience for dying patients involves addressing physical symptoms, psychosocial concerns and spiritual care needs of both patients and their loved ones (Choudry et al., 2018; Puchalski et al., 2009). In the midst of the COVID-19 pandemic, providing a 'good death' for patients dying in acute care has been challenging, especially during periods of strict institutional lockdown, when acute care and long-term care settings restricted family members, friends, and faith leaders in an effort to minimize the spread of the virus. Faith communities play an intrinsic role in providing spiritual care to patients and their families at the EOL (Balboni, 2013). Offering culturally sensitive care is an integral component of EOL care (Frost et al., 2011). During the months of the strict lockdown, dying patients and their families missed countless opportunities to have their spiritual, religious, and cultural needs met. It has been noted in the literature that when a patient and their family are confronting EOL, their spiritual care needs are often paramount (Scott et al., 2008), and these may, or may not, include addressing specific religious beliefs and practices (Murray et al., 2004). In fact, "[f]or many patients, hospitalization raises spiritual questions concerning their relationship to the sacred" (Vandecreek, 2009, p. 5), as well as existential questions and spiritual distress. Notably, the hospitalized "patient is more vulnerable, since [he/she] is away from [his/her] pillars of faith" (Saad, 2016).

Unexpectedly, "this pandemic offers an opportunity for reflection on the true intent of palliative care, including the importance of spiritual care, and recognition of the work yet to be done" (Ferrell et al., 2020). This reflection emerges as we continue to witness the effects of the physical absence of our dying patients' loved ones and of their faith leaders, who provide an invaluable source of comfort and support. The specialty of palliative care is positioned to address spiritual care needs when supporting a patient facing a life-limiting illness and in their preparation for death, usually in collaboration with extensively trained spiritual care providers. Spiritual care focuses on "acknowledging [the patient's] unique life experience, being there for the patient, and respecting [them] at the point of death" (Leong et al., 2004, p. 16).

Sunnybrook Health Sciences Centre Spiritual Care Team "serves a multi-cultural, multi-faith population. The role of spiritual care is intentionally broad and covers variable aspects of psycho-social-spiritual support" (Stilos et al., 2019, p. 42). Their pastoral interventions include assessment (welfare, needs and resources of the patient); ministry (relationship, conversation, and pastoral presence); counselling (ethics consultation and education); religious rituals (Sacrament of the Sick); cultural rituals (Smudging); and compassionate support to patients and families as they navigate their grieving process (Mackinlay & Trevtt, 2007).

Stilos et al. (2019) conducted a retrospective chart audit of the Palliative Care Consult Team's database to review referrals for EOL care and analyzed the spiritual care consult notes for these patients. The review identified that the spiritual care team provided many of the

above – noted pastoral interventions. Of most relevance to this paper, 43% of the Spiritual Care Team's referrals were focused on providing the practical aspects of spiritual supports, involving "arranging a visit from external faith communities like Roman Catholic priests, Orthodox priests and Rabbis" (Stilos et al., 2019, p. 43). However, not all requests for such visits were initiated by spiritual care. Prior to the lockdown, a patient or family member could directly request their religious leader to attend at any time during their hospital admission. One such request could be for a priest to visit and administer the Sacrament of the Sick, the Sacrament of Holy Communion, or confession. For many Christians, these sacraments are essential in expressing the action of God and sustaining the hope of salvation and of heaven.

As per Rev. Fr. Haridimos, the Orthodox Christian Church believes that Christ is fully present in the Eucharist and in no way believes that the elements of the bread and the wine merely symbolize Christ's body and blood. Christ said at the Last Supper, "This is my body and this is my blood" (1 Corinthians 11:24–25), as He presented the Bread and the Holy Grail. It is the belief that the Eucharist is "medicine unto immortality" (St. Ignatius of Antioch) that leads the recipient towards the Kingdom of God, where life never ceases to exist, since the soul of each individual is immortal, similar to what the ancient Hellenic philosophers preached before Christ. Furthermore, as per Roman Catholic Priest Fr. Pheal Bussiere, the example of communion, as expressed in Orthodoxy, illustrates that these are not just optional rites. In the hearts of the faithful, there is profound comfort and assurance of God's presence in confession, communion, and anointing. The practice among Churches varies, but the presence of a priest or ordained minister is required for administration of the sacraments.

Throughout the lockdown, the Spiritual Care Team endeavoured to address the challenges facing patients and their families. One initiative introduced video conferencing for patients admitted to acute care. Electronic tablets were provided to patients not previously virtually connected, to enhance their communication with their families, loved ones, and faith leaders outside of hospital (Stilos & Moore, 2020). Providing care by phone or through virtual platforms contributed to the comfort and spiritual well-being of these patients.

Sacraments can provide hope, meaning, and solace to patients and their loved ones (Canadian Virtual Hospice, 2003–2021), yet could not be conferred virtually, as they require direct contact and physical touch. The inability to involve external faith leaders limited the role of the internal spiritual care team in facilitating the provision of pastoral interventions and thereby, compromised the team's ability to meet all the spiritual care needs of hospitalized, seriously ill patients during this pandemic.

As the pandemic evolves, hospital-based palliative care clinicians, spiritual care teams, and external faith leaders are able to recognize and reflect on the shortfalls of delivering comprehensive EOL care in acute care and long-term care settings and are willing to collaborate in addressing these gaps. The pandemic highlights the need for broader palliative care planning, consisting of four fundamental pillars: symptom management, staff (capturing the spiritual care team under this domain), space, and systems (Christian et al., 2008; Downar & Seccaraccia, 2020). Together, we must think more broadly about how to include resources beyond the walls of our institution, particularly when there are existing external faith communities willing and able to assist in these unprecedented times. Moreover, we submit that proactive palliative care pandemic planning necessitates the development of a flexible, yet acceptable, process for patients desiring the attendance of members of their external faith community. This would require the organization's accommodation for community faith leaders, including both provision of Personal Protective Equipment (PPE) such as masks, gloves, gowns, and the dedicated training required for proper donning and doffing of PPE. This would also require addressing operational limitations, including the current hospital uniform dispensing machines, which are synched only with hospital staff ID badges, and the lack of physical space for community faith leaders to change their clothes, wash their hands, and store their personal belongings.

The impact of the pandemic on dying patients' families will permanently impact their EOL care, as well as healthcare providers and the healthcare system as a whole. The glaring void in the provision of a "good death" has timely implications for the clinical practice setting, and we must adapt to respond to future challenges. This is relevant as we serve a diverse population with various cultural, spiritual, and religious beliefs. When we do not address people holistically, "at stake is the health and well-being of our patients and satisfaction that we as healthcare providers experience in delivering care that addresses the whole person—body, mind, and spirit" (Koening, 2012). There is no time like the present to critically appraise how we can improve the EOL care we are providing. We need to move forward in expanding our models of care to ensure and enhance the spiritual care delivery practices, both during this pandemic, and beyond (Ferrell et al., 2020).

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