The Critical Role of Spiritual Care in the Emergency Department

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ABSTRACT

Patients in the Emergency Department (ED) have a diverse set of spiritual challenges. As part of a clinical initiative to embed palliative care in the ED, our palliative care department looked to provide timely spiritual care (SC) to this population. We worked with three of our chaplains to identify ED-specific spiritual care challenges and benefits. Several themes arose on nuances of SC consults in the ED: quality of consults (less focused on actively dying patients, more upstream support), challenges (physical environment, staff limitations, distractions), benefits (continuity of care, support to the ED staff, high moral/spiritual distress in the ED setting, provider-rewarding care, taking advantage of long ED stays), and ways to improve (embedding SC in the ED, education on scope of service provided by SC). Addressing spiritual and moral distress is a key component of high-quality palliative care and may be a feasible patient-centered outcome to address in future research.

KEYWORDS: ED-embedded palliative care; spiritual care; patient-centered outcomes

BACKGROUND

ED-Embedded Palliative Care (EDPC) is a relatively new model for providing timely supportive care to acutely and chronically ill patients with life-limiting diagnoses in the acute care setting. As of 2024 there were approximately 15 programs providing this type of care nationally,[1] with significant growth anticipated, as data has shown that this type of integrated program provides goal-concordant care, decreases healthcare utilization,[2] and improves ED staff satisfaction.[3] Little has been published on patient-centered outcomes from these programs. To identify potential areas for future investigation of patient-centered outcomes, we wanted to highlight the role spiritual care plays as part of the PC interdisciplinary team in the ED.

Patients in the ED have considerable spiritual care needs. Spiritual care (SC) services are a critical element of holistic, patient-centered palliative care (PC)[4] and should be included in ED-embedded PC programs. Grutzen et al included spiritual needs in their list of palliative care needs of older adults presenting to the ED.[5] In a review of providers in ICUs and Emergency units in Spain during COVID-19, 66.7% considered SC of high importance.[6] ED providers view spiritual care services positively, although it is often equated completely with religiosity.[7] Despite these identified needs, the barriers often cited to providing quality palliative care in the ED also exist for providing spiritual care in this setting, including high acuity diagnoses, lack of services available in "off" hours, fast pace, limited privacy, crowded setting, and limited information on prognosis at time of visit.[8,9] We hoped to better define these barriers as well as specific benefits provided by spiritual care in the ED setting.

FINDINGS

In 2022, Brown University Health implemented an EDPC program at the Miriam Hospital in Providence, RI. The hospital is a 247-bed hospital with 70,000 ED patient visits per year. In the first nine months of this program, 409 patients were seen by the EDPC program.

Patients admitted to the Miriam Hospital have access to spiritual care support from multiple non-denominational chaplains seven days a week. Consultation to the spiritual care service can be triggered by medical providers, nurses, or social workers when they believe the patient would benefit from spiritual support or if a patient or family requests their services. While this is a well-structured, inpatient, support program, the role spiritual care providers fulfill in the ED is less defined.

In developing the EDPC program, we characterized the role of spiritual care in the ED and consequently, we saw parallel growth in the number of patients receiving spiritual care support from our interdisciplinary team after starting the EDPC program. In the nine months before initiation of ED-embedded PC (01/2022–9/2022), there were 29 SC consults performed in the ED. In the nine months after initiation (10/2022–06/2023), there were 94, representing more than a 300 percent increase in consult volume. These consultations were in large part placed by the palliative medicine physician embedded in the ED, after discussion with patients and the treatment team.

To identify how ED-initiated spiritual care consults differ from inpatient-initiated consults, semi-structured interviews were conducted by a physician with three spiritual care providers in our department who spend time seeing

patients both in the ED and in the inpatient settings. Common themes emerged, and a summary of their responses are grouped below.

How do typical ED spiritual care consults differ from inpatient consults?

Acuity and speed: *All three chaplains identified that the patients they see in the ED tend to be sicker and consultations need to occur more quickly than those occurring on the floors.*

- "ED SC consult tends to be very acute, very intense, before they die."
- "The speed is different from the floor. There are nurses and doctors running in and out."
- "Typically, they are more acute."

Actively dying patients: *The chaplains commented that many consults in the ED are for a prayer or last rites before dying. This was especially true prior to embedding a palliative care physician in the ED.*

- "People are usually actively dying. Normally the patient isn't responsive. Family is gathered at the bedside. When the ED puts in a consult, it's really at the last moment. Almost thinking of us in a sacramental manner like someone has to come and say prayers and "do the religious thing.""
- "Very often they are end of life – That was probably 95% of the consults."
- "Not many and only patients in end-of-life situations."

What are the barriers to effective spiritual care consults in the ED?

Physical environment: *Physical space is a well identified barrier to effective GOC discussions in the ED that resonated with the chaplains.*

- "It is so crowded. I don't really have a way to create a calming environment for a chaplain to be there. Very close and only a curtain. Some have a door. Always noise around you."
- "Sometimes the rooms are small, staff are running in and out. We physically feel like a barrier to staff doing work. The nurse comes in, the doctor comes in, and I am physically between them. Timing, business, the physical space."

Staff limitations: *Chaplains encountered difficulty getting information on the patients from providers and nurses given the chaotic environment.*

- "The staff are just so incredibly busy – 'I have so much to do I don't have time to talk to you.' They are really busy."
- "Rounding didn't really work because the staff didn't have time. The urgent nature of it all – you would think we are needed, wanted more. Sometimes people are really stressed out in the midst of what they are going through and staff doesn't think of us, because everything is so urgent. Instead of adding in an added layer of support, we just slip their mind."
- "They are so busy and intense down there, it's just one more thing for them to do."

Distractions: *Chaplains identified that their usual environment for supportive discussions is a calm and quiet area which is different from the ED.*

- "How can I really help support when there are so many distractions."
- "There is a lot of distraction. In the midst of a very important conversation, the doctor needs to talk to them. On the floor, the doctor usually can give me 5–10 minutes."

Implementation of tools to overcome barriers: *Chaplains have found that even brief initial visits are beneficial. Practicing through the isolation barriers of the COVID pandemic gave chaplains tools to implement during ED visits*

- "I try my best. Even a very short time to tell them I'm available for anything, even if it is abbreviated and letting them know I will check back later. They are appreciative."
- "Being able to say a prayer for them, they so appreciate it. Even in a brief visit."
- "Because of my training I have seen people in shared rooms, in halls, during COVID. I make a cocoon around us."

What are the benefits of ED-initiated spiritual care consults?

Support for ED staff: *Just as a palliative care team supports the patients, they often support the staff who are treating complex patients. This concept held true in the ED setting.*

- "There is moral distress on the team that they can't be with all the people suffering. When patients' needs are being met, it lowers the distress of the staff."
- "We are supporting the medical team."

Continuity of care: *The chaplains appreciated being able to see their patients early in their course and help them process right from the start, especially in cases where they may be getting difficult news.*

- "More proactive consulting, earlier in the process, earlier in the disease trajectory. They are not at death's doorstep. People have come to the ED, they have met with palliative care, they have gotten discouraging news and they are kind of adjusting to that news. They are using SC as a way to process. They are better able to process what they are facing but also able to integrate their spirituality to help them to cope, adjust, or even have some well-being even if the news is 'bad.' Ex.: 'I'm going to die but with

my spirituality and my faith I can get through this.' We are called in earlier so are we better able to support."

- "When you say 'I met you last night in the ED,' they say 'oh yes!'"
- "It is such a relief when they are admitted and you see them in the room."
- "They go, 'Oh, someone I know, I can trust you.'"

Providing real time spiritual support: *The chaplains are often physically present for patient deaths in the ED. Being bedside during this final moment for patients, families, and staff allows for more acute support.*

- "These are sudden deaths, so you are dealing with families that are just stunned. If they have any kind of religious background they completely forget [about their religion in the crisis situation]. So, when you say, 'Do you want me to say a prayer?', they [remember and] say 'Yes!'"
- "The last thing they can give to their loved one before they die. Talk about legacy and what meaning they brought and what will you remember about them. It's not closure. Ritual is really important. It's so cold to be like, 'They died, goodbye.'"
- "It is very moving to the family if providers stay for a prayer."

Moral and spiritual distress are particularly high in ED setting: *Chaplains identify a high burden of moral and spiritual distress in patients in the ED, which indicates a particular benefit from spiritual care support in this setting.*

- "When the patient comes into the ED to deal with the illness, they don't know what's going on, the level of anxiety is through the roof. They are worried if they are going to make it…[They are] thinking, 'I need some prayer, some support from the chaplain, the priest, the rabbi.'"
- "To help them in a time of turmoil. Being able to bring the calming presence and help them process. The anxiety level starts to come down. They feel they are not alone."
- "Our ability to sit down and help people and really help is of deep meaning and value to them. Sometimes when they are processing and able to adjust with their values. 'I am in deep grief, what's going to sustain me in the midst of this?' Sometimes it's deeply religious and sometimes it's existential without religious ties."

Bridge to the inpatient team: *Meeting patients in the ED allowed chaplains to inform the inpatient providers, nurses, social workers about the patient's psychosocial situation and level of distress to ease transitions during the hospitalization.*

- "[ED consultation] creates a bridge to the inpatient world. When we have met them in the ED and we had that initial processing conversation, it actually makes it easier when they move to the inpatient; we have that rapport. It has helped with creating long-term relationships."
- "We get to start with them and then there's this continuity. I can inform the team on the floor about the emotional and social dynamics, the spiritual, the relationships. It moves the ball forward so much more quickly rather than someone languishing."
- "Rapport building gets built quickly in those moments."

Work satisfaction: *All three chaplains noted the high need and benefit of providing spiritual support in the ED and found it to be a rewarding part of their practice*

- "It can be busy, but I really enjoy it because I see the need."
- "Sharing the experience and being able to give you the updates about the patient."
- "I always wish we had more consults from the ED. The sooner we're involved the better. Typically, if they are getting admitted because their 'number one person' is often accompanying them. You are able to establish a bond with them because you were there in their moment of crisis, even if they are not unpacking everything."

Takes advantage of long ED stays: *ED-boarding results in prolonged time in the ED during which patients suffer distress.*

- "People are in the ED for 'how long?" We could see them the next day but what if they are still there the next day. What if they are sitting there for 10 hours? We might as well take advantage of those 10 hours."

How can we improve spiritual care consults in the ED?

Embedded spiritual care: *Two chaplains had experience with hospitals where there were chaplains embedded in the ED and enjoyed that experience. They discussed the relationships they formed with the providers and staff and found being embedded overcame many of the systemic barriers to spiritual care to those patients who would benefit.*

- "It's relational. I can go and give education. But if they see you at work and know you and trust you. Because we are not consulting as much, the relationships are harder to build."
- "Showing them the value of what you do."
- "We would embed the interns in the ED, and we got such positive feedback because people understand what we do."
- "The situation of a sudden death that was distressing to family and providers – no chaplain was called. If they were embedded in the ED, they would be there."
- "Round in the ED. Everyone in the ED has spiritual needs: 'What's going on? Who are my people?' It's just simmering there. They just sit there for hours. And to

have someone check in on them. Sometimes it would be a very serious spiritual discussion. 'It would be really great if I had a rosary.' Guided meditation to lower their anxiety."

- "Go across the board and introduce myself. Balancing seeing the most acute with putting it on ED staff to place an order. Out of sight, out of mind. They see us and know us and know our work. It's hard because we are not embedded there."

Is there anything you want the ED staff to know about your role?

Understanding scope of SC practice: *Social workers are routinely part of the ED environment. Our chaplains wanted to highlight that they provide a particular set of skills that differ from social workers. In addition, they have found that most people in the ED only think of them as being able to provide prayer near the time of death and might not realize the benefits they provide for patients who are not in the actively dying phase.*

- "I think that they are so used to leaning on the social workers, and we are not as culturally involved."
- "They misunderstand our role. Hospital chaplain serves a larger role than a priest or a pastor. They pigeonhole us – 'Well it doesn't matter, they aren't dying.'"
- "I wish people understood what that means rather than just bringing me in for a prayer. The benefit to the patient. They can have those discussions early on and its sets them up to cope better and earlier."
- "The biggest hurdle we have to overcome is the concept of what our role is, the training, the scope of our service. They only see us at the end of life when we pray with the family."
- "They don't always want a 'religious' person involved."

CONCLUSIONS

Interviewing three seasoned chaplains gave incredible insight into the unique benefits and challenges they experience in providing spiritual care support to ED patients. Their experiences highlight the important need for spiritual care support for patients presenting to the ED. Given that identifying and addressing spiritual and moral distress is a pillar of high-quality palliative care, it should be a key component of EDPC as well. As we move toward identifying patient-centered outcomes of EDPC, one next step would be to identify from the patient perspective what may be the perceived benefits of receiving spiritual care support in the ED.

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