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FROM THE INSIDE

A personal trip into spirituality and religion in critical care

Paolo Pelosi*

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Editorial note:

With profound sorrow, we announce the passing of Professor Paolo Pelosi, a distinguished figure in the field of Anaesthesia and Intensive Care. Professor Pelosi succumbed to a brief illness on May 30, 2023. Just 1 day before his premature departure, he graciously shared some thoughts with us. We are proud and honoured to be able to share this work with the readership of Intensive Care Medicine. We also warmed by the understanding that Professor Pelosi, to his end, remained curious and insightful. His passion for education and teaching sung out, even in his very final days, and what has been left for us is a challenge—to consider something anew.

A phone call can change your life—and that of your loved ones—forever. I am an anesthesiologist and intensive-care physician, and for 30 years, I have split my time across clinical management, teaching, and research activities. My lifestyle has been healthy: I am a nonsmoker, perfectly fit, someone who focuses on my hospital and university duties and enjoys the constant support of my wonderful family.

December 2022 in Liguria was a day with clear weather and fresh air, like many others. I woke up early in the morning, had breakfast, and sprinted to catch my train to get to the Hospital on time, where my usual duties awaited. Then, a call came to my cell phone:

"Are you Dr. Pelosi?"

"Yes, of course" I replied and my voice came calmly.

"Dr. Pelosi, I wanted to inform you that we found an enlarged lymph node in the mediastinum and a suspicious lesion in the right upper lobe of the lung. Don't worry, but you need further clinical investigation".

Then "thank you"—an unforeseen event.

Further investigations were promptly pursued, leading to a diagnosis of lung adenocarcinoma, followed by surgery, chemotherapy, and treatment modification based on my clinical response. Then, I suffered a severe complication—a large pleural effusion, which required admission to the intensive care unit (ICU) and, subsequently, the medical pulmonology ward, from which I was discharged a few days later with a permanent right-sided pleural catheter and a need for supplemental oxygen both at rest on exertion.

There are several critical issues which have defined my journey, things which I can say are mainly related to different fears and dealing with an unknown and uncertain future. Firstly loss of physical independence, with reduced ability to carry out my daily activities and duties, secondly, the need for indefinite leave from work, next, the weight of recurring doubts and questions throughout the day, but also especially at night, focusing on what went wrong and what I could have done to avoid this situation—"is suffering a sign from God?" I ask myself. In turn, I am taken by an understanding of an excessive family workload at home, with administrative burdens leading to anxiety and, finally, the panic of experiencing intolerable dyspnoea, suffocation, and severe pain.

My first reaction was defined by a need to isolate myself. I became engaged in regarding myself "from the outside" as a clinical case. I gave colleagues clear advance directives concerning my decision for sedative palliative care when deemed necessary.

Disease, suffering, pain, and death are too often minimized and forgotten, since they are usually considered a loss. We regard these as things which should not happen, as an unexpected intrusion on life.

*Correspondence: intensivecaremedicine@unimib.it
Editorial Office, Intensive Care Medicine, Milan, Italy

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I have found that suffering, especially unforeseen, can be something valuable: a great awakener of the soul. Of course, the search for the "why" of illness, suffering, pain, and death is always tiresome, but I believe that this can be doubly so when their meaning is unknown. Thus, I started a journey to the center of my soul.

I am a very religious man, and I know that the modern concept is to separate physical health and disease from spiritual factors. Conversely, I still believe that we are best served by a "holistic" view of disease and suffering, where we consider the three components—"body", "mind", and "spirit"—together, not separately. It is important to continue respecting patients' wishes in each of these realms, including using modern technologies; "I want to arrive at death alive".

I believe that the *person* should always hold pride of place over disease and suffering, as long as the progression of their clinical condition allows. Personally, I found prayer to be important, providing a means of "contact with the Lord". Also valuable were discussions with chaplains. On a spiritual level, they led me to the concept of "trusting" in God and practically they allowed me the possibility of receiving the Eucharist in hospital. In the words of Saint Philip Neri, "Keeping one's good humour in the midst of sorrows and illness is a sign of a good and upright soul".

Several barriers may account for the lack of spiritual and religious care in the ICU. First, physicians may miss opportunities to address spiritual concerns with patients and their families, likely due to a lack of time and of training aimed at developing the skills to detect patients' spiritual needs. Second, this is impacted by underutilization (as well as reduced visits to ICU patients and families) of chaplains, who are specially trained to attend to patients' spiritual needs; third, differences in the organization of spiritual and religious support between different hospitals and countries; finally, patients with altered level of consciousness may not derive tangible benefit from spiritual care. Nevertheless, even in those circumstances where a patient is not conscious, there may be benefits for family members around them. Moreover, healthcare professionals can play supportive roles in addressing the spiritual care needs of family members as they experience the challenge of critical illness. Although the patient's religious views should be respected in most cases, I know it is naive to think that religion and medicine can always coexist in harmony. A physician should not provide treatment that confers no benefit or indeed that harms the patient, even if requested on religious grounds. Religion may be profoundly important to some patients, as it is to me, but it is not a trump card that can force doctors to violate fundamental ethical values.

Several questions related to the delivery of spiritual and religious care and their impact on critically ill patients remain unanswered. First, the improvement of spiritual care education for patients, families, and healthcare professionals (including those who take chaplaincy to the hospitals). Medical and nursing schools and religious schools should include themes relating to spiritual and religious care in their curricula. Second, our ability to identify critically ill patients and those families who need spiritual care should be improved. Third, more attention should be given to the spiritual care needs of healthcare professionals themselves. Fourth, research on this topic should be conducted and guidelines developed, considering the diversity of spiritual manifestations among individuals, hospitals, and countries.

Critically ill patients facing physical suffering and pain should be supported in all their complexity, with a "holistic" approach reconsidering the spiritual (spirit), the psychological (mind), and the physical (body) realms as one. This is 'the person' and the person should always have a prominent position above their disease and suffering. We should encourage intensivists to utilize available hospital resources and take actions that promote a spiritual and emotional understanding during patient interactions, family discussions, and in the way we educate our teams. I hope that such an approach may break the current silence regarding the place of spirituality and religion in critical care medicine.

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