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THE IMPACT OF THE SPIRITUALITY OF INTENSIVE CARE PEDIATRICIANS ON THEIR PERFORMANCE

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ABSTRACT

INTRODUCTION: In view of the comprehensive care of patients in general, spirituality and religiosity are an integral part of care. Studies show that spiritual practices improve mental health, quality of life and interpersonal relationships. The same is true of pediatric intensive care physicians who deal with the suffering of children and their families on a daily basis. **OBJECTIVE:** Verify the religiosity / spirituality of Brazilian pediatric Intensive Care Unit (ICU) doctors and how it influences patient care and coping with personal stress. **MATERIAL AND METHOD:** Cross-sectional study with a quali-quantitative approach, carried out through online questionnaire answered by pediatricians from the Intensive Care Unit who are part of the Brazilian Association of Intensive Care Medicine. **RESULTS:** 148 pediatric ICU doctors answered the questionnaire. 83.1% said that spirituality / religiosity greatly influences the patient's health, as well as interfering in the health-disease process, in a positive way, however, 50.7% felt partially prepared for this dialogue. **CONCLUSIONS:** Religion / spirituality is a way of coping with stress or suffering, facing the end of a child's illness, both by the family and the doctor. The need for spiritual accompaniment is recognized by most doctors, however, this is not done systematically in most ICUs.

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INTRODUCTION

Spirituality and religiosity are related concepts that, although they are generally used interchangeably, do not have the same meaning. Spirituality encompasses human needs, and may or may not involve religious beliefs, to provide a philosophy or guiding perspective for the choices of human beings (Cervelin *et al.,* 2014). On the other hand, religion can be understood as a group or system of beliefs that involve the supernatural, sacred or Divine and moral codes, practices, values, institutions and rituals associated with such beliefs (Kemp, 2006). Reflecting on spirituality and religiosity as part of comprehensive health care provided by pediatricians in an Intensive Care Unit (ICU) is very important, as these professionals go through difficult situations, emotional distress and spiritual experiences that broaden their perception of the topic. In addition, the number of patients and family members who invoke to spirituality and religiosity in times of illness, such as seeking support and comfort, is numerous. Therefore, it is necessary to include spiritual aspects in care, due to the professionals concern in offering a whole support to their patients. As highlighted, the spiritual dimension is an integral part of the care for pediatric patients and therefore the health team needs to be able to deal with this movement of transcendence (Garanito *et al.,* 2016).

Children, in particular, do not distinguish between spirituality and religion, but their spiritual sense or commitment to a religious community can promote positive coping in the face of their illness[6]. It is essential that pediatricians, especially those in the ICU, be alert to reports from the family and the patient in order to build a communication and spiritual assessment skill regarding those under their care(Garanito *et al.,* 2016). Regarding the medical assistance of the pediatrician on the spirituality of the patient and his family, there are difficulties in carrying out spiritual care, such as the approach to the patient and his beliefs and also the lack of knowledge of spiritual assistance in order to promote comfort in this regard. Another very important factor is the lack of knowledge and respect about the particular aspects of the other's religion. To provide this type of care, the professional needs to have the courage to break prejudices and paradigms, as it is necessary to be sensitive and respectful, that is, to be at the side and not above the patient. The critical nature of patients admitted to the ICU can lead them to a process of greater vulnerability, isolation and alienation, which provide even more the need for comprehensive care, with regard to spiritual care(Carpenter *et al.,* 2008). It can also be emphasized the advantage in the professional's flexibility to incorporate positive techniques of spiritual care in the treatment of patients, and mainly, being able to early

identify spiritual conflicts, which could allow interventions and avoid harmful consequences to treatment(Trevino *et al.,* 2010). Practices can include: mental support and perception of spiritual needs, facilitating religious practices, communication with the patient and their family members and including the family in the participation of care(Timmins *et al.,* 2008). The religious beliefs of these doctors are considered a factor that strongly influences the perception and attitude towards the patient. The professional's religiosity is a means of promoting his mental health and adapting to the existing stress in the health area, especially sectors where living with pain and suffering is inevitable, even when the alternatives are not favorable (Manenti *et al.,* 2012; Pina *et al.,* 2008). Despite all the advantages of approaching spirituality, as a source of well-being and quality of life when approaching suffering and death (Wachholtz *et al.,* 2006), few doctors perceive the spiritual needs of their patients. Reports show that doctors in general feel uncomfortable when talking about religious matters or that they do not have time to deal with it. Others do not consider spiritual matters as part of their work, do not understand why they should be, do not know how to introduce them and do not even imagine what the results would be (Manenti *et al.,* 2012). In addition, they are afraid to impose their religious beliefs, breaking the doctor-patient relationship. Communication problems on this subject are more frequent in the care of children and adolescents. Research shows that the discussions about spirituality reported in the medical records were characterized as frustrating in relation to the perspectives of the family and the patient himself (Cervelin *et al.,* 2014). There is no denying that death is a common reality in hospitals, especially in sectors such as the ICU. Dealing with the constant perspective of death, often accompanying this process of singular confrontation of patients, isolated from family and loved ones, makes this reality more difficult and challenging. When it comes to a child, the feelings intensify, because, even though death is an inevitable fact, it is extremely difficult to accept that it happens early, in the first stages of a human being's life. Reporting the death to the family is even more difficult, however religious and spiritual beliefs provide a way to respond to the concerns of family members, thus serving as a support and source of relief for these individuals. In order to have a religious experience, it is necessary to start from your own experience, this cannot be totally disconnected from your religious conditioning and from your lived culture. “Welcoming each one's spirituality is equivalent to respecting it in its uniqueness” (Frankl, 1991), this means that the professional must be sensitive to hearing and understanding expressions of faith, hope and human beliefs, without worrying about imposing their own opinions, beliefs and dogmas. When it comes to spirituality and religiosity, there are gaps on the subject, such as: their role in situations of grief and death, strategies to alleviate spiritual suffering and ways of establishing dialogues in the doctor-patient relationship. Clearly, there are greater difficulties when the patient is a child in the ICU. In this context, it is essential to understand how pediatric ICU doctors deal with the suffering of these children in their daily lives and whether spirituality and religiosity are part of this confrontation.

MATERIALS AND METHODS

This is an exploratory, cross-sectional study with a qualitative and quantitative approach. After the approval of the Ethics Committee, an online form was made available via email to pediatric doctors who have been working in a pediatric or neonatal ICU for more than six months. This was performed with the help of AMIB (Brazilian Association of Intensive Care Medicine). The form was made available for two months and responses obtained after this period were disregarded in the data analysis. After collection, responses and reading of all data were counted. In the next step, the information was categorized and the process of integrating the categories began.

RESULTS

148 intensive care pediatric physicians participated in this study, predominantly female (73%), aged between 35 and 45 years, who have worked in the ICU for more than 5 years in hospitals with 6 to 10 intensive care beds. The answers came from at least one person in each state of Brazil, being predominantly doctors from São Paulo (26.4%) and Rio de Janeiro (14.2%). Among the participants, the majority declared themselves to be Catholic (45.3%). There are 11.5% spiritualists, who do not have a belief, but believe in a greater “being”. Only one doctor declared to be Jehovah's Witness (0.7%). Despite the existence of atheists and spiritualists without religion among the sample, 93.9% believe that the human being is composed of physical body and soul (Table 1). 83.1% said that spirituality / religiosity greatly influences the patient's health, as well as interfering in the health-disease process, in a positive way. In addition, 64% stated that there is a great deal of relevance in addressing spirituality and religiosity, although 6% stated that there is no relevance in these matters. Regarding the interference of spirituality and religiosity in the doctor-patient relationship, 62% said yes, there would be a lot, while only 4% reported believing that there is no interference.

Table 1. Religious affiliation of participating physicians

Variable	N = 148
Beliefs, n (%)	
Buddhists	1,4
Catholics	45,3
Spiritists	26,4
Espiritualists	11,5
Protestants	8,1
Jehovah's Witness	0,7
Atheists	6,8

Note: Categorical variables are described in number (percentage).

During medical practice, 38.5% of the participants stated that they had studied a little on the subject of spirituality. However, 50.7% felt partially prepared for this dialogue. As explained above, although 64% stated that there is a lot of relevance in addressing the topic, only 27.7% talk about it with their patients and family members frequently, and the conversation is not always noted in the chart.

More than 50% felt able to discuss the issue with their patients and family, but only 6.8% reported that there was no barrier that prevented them from addressing the topic. Discouragement barriers were found to discuss spirituality and religion, such as the fear of imposing their belief or offending (41.9%). Other barriers were pointed out by the professionals in question: lack of knowledge or training, resistance of the patient's family members, discomfort and dependence on the patient's health status (Table 2).

Table 2. Discouragement barriers to discuss spirituality

Variable	N = 138
Barriers, n (%)	
Fear of imposing your belief or offending	41,9/93,2
Lack of knowledge or training	30,4/93,2
Does not find it relevant	7,4/93,2
Family resistance	6,0/93,2
Discomfort	5,4/93,2
Patient severity	2,1/93,2

Note: Categorical variables are described in number (percentage). The second number (93.2) is the sample size of the participants who explained a discouragement barrier.

As for being asked whether the professional thought it was appropriate to pray with his patients, 10% reported that they never did so and 62% said that only when the patient asked. On the other hand, more than 70% of doctors have already asked for religious help for their patients, 99% of whom allow religious rituals for children hospitalized in the ICU, as they believe that this has a positive influence on the treatment.

In the sample of this study, 62.8% of the participants had children. Of these, 62.4% believe that the relationship with their children influences the way of dealing with their patients, while 8.6% stated that there was no association. In view of the doctor-patient relationship and the doctor's view of the patient's illness, 63.5% believe that their religion interferes with the way they look and react. When a patient dies, 36.5% justify the fact with a religious

perspective, as their own religion helps to cope with suffering and stress when working with terminally ill children. Among the 148 intensive care pediatricians who participated in the research, 85.1% stated that they had no prejudice and were not against the discernments of any religion. However, 14.9% said they were against some religions, mainly Jehovah's Witnesses (74%), followed by African (25%) and evangelical (1%) religions. The main reason for religious repulsion in relation to Jehovah's witnesses involves resistance to blood transfusion, while the other religions cited have described the following reasons: limiting belief, extremists and negative influence on individual and collective freedom.

DISCUSSION

This work showed the importance of spiritual and religious issues in the doctor-patient relationship in critical situations, especially in the pediatric ICU. At the same time, it was noted the difficulty of intensive care pediatricians in how to deal with these issues, the fear of imposing their beliefs and prejudice against some religions. Most of the doctors who participated in our study considered themselves to be religious, but those who drew attention were those who called themselves atheists, that is, they correspond to those who do not believe in God or in any "superior being". The word has its origin in the Greek “atheos” which means “without God, who denies and abandons the gods”(Freitas, 2011). Despite this, this small part of the sample (20%) also believes that the human being is composed of physical body and soul, as well as, they approach the subject with their patients and family, as they believe in the influence of religion and spirituality in the health- disease. In Brazil, 90% of the population are religious affiliates, predominantly Catholics and Protestants. In this vast majority, there are still other religions and movements that are growing more and more(Sousa, 2013). There are those who designate religion as a philosophical or spiritual concept, however, it is necessary to remember, that any doctrine raises reflections about life and death, as well as it is based on some supernatural God or “being”(Ames, 2006). In each historical and socio-cultural context, society seeks a way to answer its questions. Religion is a necessary good for humanity, but unfortunately there is still a lot of intolerance. This is because people are unaware of each other's faith and are not even aware of what religions preach in their work. Therefore, in the medical field, the essential thing is to have respect and tolerance in the face of the belief of their patients and family members(Corrent, 2016). Our study showed the importance of the topic confirmed by the participants, according to what is already observed in the literature(Cervelin *et al.,* 2014). In general, doctors stressed the importance of the issue in their work environment, but made it clear that there are still barriers that make dialogue impossible, such as lack of preparation, religious disgust or fear of imposing their beliefs. As seen in recent studies, health professionals have some mistaken thoughts, for example: “this is not part of my job” or “this is not relevant for the treatment”, it prevents the necessary spiritual or religious dialogue for the patient. However, these barriers will be broken down as the doctor deepen into the topic and frees himself from anxieties and prejudices (Evangelista *et al.,* 2016).

It is noted in this study that religion and spirituality are a way of coping with stress and personal suffering, in the face of a child's illness or terminality both for the family as well as for the doctor, interfering in the look at the health-disease process of each patient. According to previous research, there are difficulties in carrying out spiritual care, which consists of approaching the patient regarding his beliefs, such as the lack of knowledge of spiritual assistance, what the professional could offer and what strategies could be established to promote comfort. Therefore, in this study we can explain what are the main barriers that prevent this direct contact: fear of imposing your belief or offending, resistance from family members, lack of knowledge or preparation and finally, for not finding it relevant. In view of the sample, it can be seen that many professionals are unsure about their own religion or spirituality. Some inconsistencies were noted, for example, atheists were interested in spirituality and religiosity, with 60% discussing the topic with their patients and family members. However, professionals, in this case pediatricians working in the ICU, must first recognize and be aware of their own spirituality in order to be able to work with the spirituality of others. An interesting aspect was to verify the participants recognition of their own prejudice against some religions, especially Jehovah's Witnesses and Umbandists, the first regarding the prohibition of blood transfusion and the second probably due to rituals.

The present study shows that spiritual and religious care positively interferes in the health-disease process and the importance of addressing the subject in the ICU. Children, in particular, do not distinguish between spirituality and religion, but their sense of spirituality or commitment to a religious community can promote positive coping in the face of their illness(Evangelista *et al.,* 2016). In addition, spirituality is present in therapeutic care in the ICU, so it is of great importance to recognize and accept that emotional factors permeate this sector, so the lack of information and awareness can trigger conflicts and emotional and psychological imbalances (Santos, 2013; Carpenter *et al.,* 2008). Dealing with lives almost always in fragile situations, making decisions and intervening in a precise clinical way in the sick, leads to psychological distress for the doctor, especially in ICU pediatricians, who in addition to caring for a child, must explain their actions to the family of your patient. The death and / or suffering of an individual are not the only factors that pediatricians need to deal with, feelings of helplessness and sadness, loss of control of the situation of their critically ill patient and the impossibility of doing something positive are also considerable(Machado, 1997). In the sample of this study, 62.8% of the participants are parents, of these 62.4% said that the relationship with their children influences the way of communicating with their patients. These data make us reflect that having children could be a positive factor for the doctor-patient relationship, and one generates greater professional attention in relation to the treatment of someone else's child to the detriment of their on (Silva *et al.,* 2013). The difficulty of the study was to approach Brazilian pediatric intensive care physicians via remote, by e-mail. The questionnaire for this study was sent by email to 3,400 Brazilian pediatric intensive care physicians associated with AMIB (Brazilian Association of Intensive Medicine), but only 148 answered it. It can be emphasized that many professionals recognize the importance of scientific knowledge, but are not qualified to help researchers for reasons that can and should be deepened. The need for spiritual accompaniment is recognized by most doctors, however, this is not done systematically in most ICUs, both in Brazil and in other countries(Manenti, 2012). The presence of a specialist in the area within the team, such as a chaplain, is recommended especially when we are talking about palliative care(Pina *et al.,* 2008), but it would also be interesting in ICUs, to help with the health team(Manenti, 2012). In this context, it is still necessary to understand in detail the difficulties of doctors in relation to religion and spirituality, to help them to be more sensitive when listening to and dealing with human faith, hope and beliefs, without worrying about imposing their opinions, beliefs and dogmas.

CONCLUSION

Religion / spirituality is a way of coping with stress or suffering, facing the end of a child's illness, both by the family and the doctor. The need for spiritual accompaniment is recognized by most doctors, however, this is not done systematically in most ICUs. In this study, we can explain which are the main barriers that prevent direct contact to approach the theme: fear of imposing their belief or offending, resistance of the patient's family members, lack of knowledge or preparation and finally, for not finding it relevant. Spirituality is present in therapeutic care in the ICU, so it is of great importance to recognize and accept that emotional factors permeate this sector, so the lack of information and awareness can trigger conflicts and emotional and psychological imbalances.

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