

The Highest Priority in the Emergency Department May Be a Patient's Spiritual Needs

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Article:

A weekend charge nurse in a 26-bed emergency department/level II trauma center is pulled in multiple directions. With alarms sounding, phones ringing, ambulances calling in, and the receptionist calling for help, it can be difficult to focus on the spiritual aspects of patients and their families. Yet, on this particular day, that was just what was most important for "John" and his family—and he hadn't even arrived yet.

Marquette General Hospital is a regional referral center on the shores of Lake Superior, and the ED doctor had just accepted a transfer trauma patient from a hospital that was 2 hours away. John was a level I trauma transfer who had multiple injuries from a fall. He was intubated and unresponsive. He would arrive about 3:00 pm, right at the change of shift. Ruth, the charge nurse, received a call from the hospital chaplain informing her that this patient was Catholic and had not been anointed before leaving the transferring facility and that the family was very concerned about this situation.

During the next several hours Ruth had a few scattered moments to reflect on just what this man's chances of survival were. He was almost 70 years old. Ruth knew that falls are the leading cause of traumatic death for people this age. Most certainly John had other co-morbidities, reducing his chances of survival. The use of warfarin, clopidogrel, and aspirin, in addition to normal brain mass atrophy, turns a minor head injury into a subdural hematoma. Brittle bones lead to multiple fractures. It became very clear: one of the most important interventions that the trauma team could perform was to meet the patient's spiritual needs, specifically the family's request that he be anointed.

John arrived at 3:05 pm. A Catholic priest arrived at 3:15 pm. Ruth took the priest to the trauma room, where John was being resuscitated by the team. She approached the physician in charge. At first, because he was so focused on resuscitation efforts, he didn't realize what Ruth was asking. Then he understood. Other members of the team moved so that the priest could join all the other specialists at the patient's bedside, and John was anointed in accordance with the family's wishes. The hospital chaplain was then able to convey this to the patient's family, who had not been able to accompany John to the hospital.

John survived to be transferred to the ICU after resuscitation in the emergency department, and Ruth went on with the day's work. While we do not know his outcome, we reflect often on this sequence of events and feel certain that Ruth's small act was critical for this patient and his family. This act, on that busy, busy day, is the one that she will always remember, and the memory of this event gives us hope on particularly frustrating days.

Addressing faith concerns is not often the highest priority for care in the emergency department, but faith is essential for many of our patients and their families, especially when death is near. Evidence-based guidelines are available that can be adapted by ED nurses to help patients maintain their spiritual health[1], [2] and [3] and integrate the hospital chaplain into everyday care.⁴ Addressing faith concerns is an intervention that helps to

maintain hope in our patients, their families, and ourselves.[5] and [6] Thus, it is up to all of us, regardless of our personal beliefs, to ensure that all the “specialists” are attending to the patient.

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