Short Communication

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The Added Value of Spiritual Care and Support in a Terminally Ill-Patient and Family

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Abstract

There are many challenges in caring for terminally Ill-patients among which include the social, emotional and spiritual distress. The spiritual care and support in a dying patient could be challenging to the carer, patient and family and often times the patients religious and spiritual and assessment and needs are not met. In some part of the world including Nigeria discussions around existential issues may be regarded as a taboo and a difficult for a care provider to initiate. The palliative care team offer to invite a chaplain is a new concept and unusual in government hospitals. This was the first time our palliative care team after spiritual care assessment involved a trained chaplain volunteer to support a patient.

Keywords: Palliative care; Cancer; Rectum; Histology; Urinary retention

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Introduction

Palliative care is a care approach that aims to improve the quality of life of patients and families facing a medical condition that threatens their continuity of existence, through prevention, assessment and treatment of pain, as well as psychosocial and spiritual care. The palliative care team offer to invite a chaplain is a new concept and unusual in government hospitals. This was the first time our palliative care team after spiritual care assessment involved a trained chaplain volunteer to support a patient.

Case Representation

A.M was a 14-year-old secondary school boy who presented to our facility with a history of progressive scrotal mass extending to the rectum. An impression of locally advanced testicular cancer was made and he was being worked up for tissue biopsy and histology.

The palliative care team was invited to review on the second day of admission. He was found to be acute on chronically ill looking, pale, in painful distress, in urinary retention, unable to lie down because of the pain and the extensive nature of the mass. He had a pain score of 8/10. The mass also had some ulcerating area discharging blood. His PCV was 29%; other parameters of the CBC were essentially normal.

The mass started growing about a year ago and he was taken to several private hospitals by his brothers but got little or no relieve. He was also taken to a native doctor where he spent seven (7) months drinking local herbs with no response. He was the 3rd child out of 6 children, both parents died in a road accident 2 years ago. His elder siblings and his aged grandmother who resides far in the village were caring him for.

Intervention

A urethral catheter was inserted to relieve the retention. He was also placed on 10 mg of oral morphine 4 hourly, 20 mg of dulcolax tablets nocte, 50 mg of diclofenac tablets 12 hourly, as well Ferrous tabs 200mg 8hourly. Social, emotional and spiritual needs assessment and appropriate support given.

Evaluation

The palliative care nurse specialist reviewed 24 h after and noticed the patient mood was still low and pain not adequately under control. Social support was still intact but further emotional and spiritual review led to elicitation of spiritual distress. He was a catholic from a different cultural background (Igbo descent) and his desire was to get baptized in accordance with Catholic rites.

He was a Christian born to a catholic family from the southeast Nigeria but had never been baptized. During the process of discussion including his spiritual assessment, he indicated the desire to have a closer relationship with God through baptism and said it would be his greatest wish if he could be baptized.

The palliative care team decided to invite a volunteer priest who came to his bedside, baptized him with members of the palliative care team as his 'God-parents' and also offered him Holy Communion.

He and the family members were elated with the baptism and amazed at the offer wishing they also had the opportunity to be baptized as well.

Results

The flowing day, he looked brighter, not in any significant distress, pain score was 3/10 and was able to tolerate some food. He was then transferred by the primary care (surgical) team to another hospital for radiotherapy and further management. Despite his referral to a bigger hospital, the family was still in contact with us till the patient passed on a week after.

Discussion

There are many challenges in caring for terminally Ill-patients among which include the social, emotional and spiritual distress. The spiritual care and support in a dying patient could be challenging to the carer [1], patient and family and often times the patients religious and spiritual and assessment and needs are not met [2,3].

In some part of the world including Nigeria discussions around existential issues may be regarded as a taboo and a difficult for a care provider to initiate. The palliative care team offer to invite a chaplain is a new concept and unusual in government hospitals. This was the first time our palliative care team after spiritual care assessment involved a trained chaplain volunteer to support a patient.

It was achieved by an interdisciplinary team of a nurse, a doctor and a volunteer Catholic Reverend Father. The patient died within a week after a referral to a bigger Centre but did not enjoy such in-depth relationship he had with us judging from the feedback received from the family thereafter. Despite his referral to a bigger hospital, they were still in contact with us and in constant feedback till the patient passed on two weeks after.

Conclusion

Most patients are in the phase of spiritual distress that accentuate their physical pain which are often under-diagnosed due to lack time or skills to evaluate.

The health care providers need to routinely take religious and spiritual history of patients in end-of-life and give appropriate care and support to alleviate unseen spiritual distress to assist them in coping with the illness.

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