EXPERIENCE EXCHANGE

Exploring religiosity's impact on end-of-life care: A call for nursing inquiry

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ABSTRACT

End-of-life care (EOLC) remains a pivotal aspect of nursing practice, yet its delivery often varies due to numerous influencing factors. Religiosity emerges as a significant but understudied determinant affecting EOLC provision. Religiosity is an all-encompassing term defining a person's public or private involvement in religious groups or activities. This opinion piece delves into the nexus between religiosity and nursing practice, emphasizing the need for empirical inquiry to elucidate its role in shaping care dynamics. Drawing upon existing literature, it describes religiosity's multifaceted influence on nursing behaviours and decision-making in EOLC settings. The piece advocates for research efforts aimed at understanding its impact on care quality and equity. By fostering a deeper comprehension of how religiosity interacts with nursing practice, healthcare systems can strive towards delivering more personalized, equitable, and dignified EOLC experiences for patients and families.

Key Words: Religiosity, End-of-life care, Nursing Ethics, Patient-centered care

1. INTRODUCTION

Although Canadians generally prefer death in natural settings, typically at home surrounded by loved ones, most will ultimately spend their last days in hospital. More than 120,000 Canadians die in acute care facilities each year; it then follows that most Canadian nurses have, at one point, directly participated in providing end-of-life care (EOLC).[1] EOLC refers to the care provided for a person leading up to their death, with the aim of ensuring maximum quality of life and dignity for a person and their loved ones.[2,3] EOLC remains a highly relevant concept in nursing for several reasons. Nurses act as advocates for patients and as liaisons between the patient and the medical team. Patients often speak first to their assigned nurses regarding their needs surrounding palliation and end-of-life.[4] Physicians frequently deliberate with their nursing colleagues when making EOLC plans, and the acts of EOLC, including providing emotional care, titration of medications, and more, are most often delegated to nurses.[5]

2. FACTORS INFLUENCING EOLC

There are many factors that can influence the provision of EOLC, chief among them, for many, is religiosity—an all-encompassing term defining a person's public or private involvement in religious groups or activities.[6] Although there are undoubtedly many intrinsic causes to account for the differences in delivered EOLC, and the complexity of relational ethics cannot solely be explained by religiosity, there still exists an empirical gap in which religiosity and its' influence on EOLC is not addressed. Much has been done to understand the importance of religion and religiosity for patients and their families at end-of-life; however, there is less research regarding religiosity and its' effect on EOLC provided by nurses.[2] Indeed, there exists a paucity of literature

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pertaining to nurses' religiosity, yet cultural and religious diversity within the profession only continues to grow.[7] Consequently, it is difficult to ascertain whether access to adequate EOLC is available for all patients, and whether discrepancies occur within the healthcare environment.[8]

Religiosity is an all-encompassing term that refers to a person's public or private involvement in religious groups or activities.[6] Religiosity is generally acknowledged by affiliation or identification with a given religious group, participation in religious activities, and having religious beliefs. From a phenomenological perspective, religiosity serves the purpose of creating meaning in life and death.[9] Spirituality relates more to a search for purpose and may not have any religious implications. In other words, a person who identifies as being spiritual may have no religious beliefs, and a person who identifies as being religious may not identify with being spiritual. Spirituality aims to derive strength from many holistic aspects of one's personhood, while religiosity refers solely to the religious aspect.[9] Religiosity is deeply intertwined within EOLC, science, and healthcare in general. This prominent differentiation between spirituality and religiosity was brought to light in the 20th century, when behavioral scientists became interested in exploring their distinction.[10] Spirituality and religiosity, while similar and share themes, are not the same. Science and religion continue to interact and influence one another; therefore, as science and health care advance, the differentiation between spirituality and religion and their separate exploration is increasingly important.[10]

3. The role of religiosity in nursing

Religiosity should not be labeled as negative, but fluid, and changing in dynamic between each nurse-patient relationship. Indeed, relational ethics and relational autonomy in EOLC is part of what defines quality EOLC. What each nurse brings with oneself will differ based on their personhood; still, patients must be provided with equal access in EOLC regardless of practitioner quiddity. In fact, religiosity is so interwoven within nursing, that it is often a leading motivation for entry into nursing as a career.[11] It is also imperative to mention that the interplay of religiosity and EOLC can be observed beyond the immediate nursing-patient interactions and is woven into policies that govern hospitals and other patient institutions. Still, religiosity's direct influence on EOLC must be further explored, so that evidence-based guidelines can be implemented to ensure patients receive equitable and just EOLC, even when accounting for differences in practitioner beliefs.[2,4,5,12]

4. Current evidence and research findings

A brief appraisal of current evidence further demonstrates the interconnection between nursing and religiosity. A journal article by Dana Bjarnason (2012) noted roots of religiosity being so deep in nursing practice that the original Florence Nightingale Pledge was a pledge before God and, although it is no longer a requirement, its' original, or a revised version is still often used in pinning ceremonies.[13] It also mentions the lack of current investigations pertaining to the intersection of religiosity and EOLC in nursing, noting that it is grossly missing in literature, and often only explored through the lens of a physician scope.[2,5]

Chandler (2018) investigated nurses' beliefs on EOLC, including that of religiosity. An online survey was sent via email along with a consent form, to eligible members within participating hospitals in the United States. It was found that religiosity is a major factor influencing nurses' beliefs pertaining to death, dying, and providing EOLC. The results of the study proposed that religiosity has behavioral implications which can account for some differentiation of practice in EOLC, and that nurses' behaviors while performing EOLC could be predicted, in part, by their religiosity. This study, similar to the work of Bjarnason (2009), did not seek to propose any recommendations for practice, however, focused solely on the exploration of the well-documented gap in research.[2,14]

A questionnaire-based study in the United Kingdom explored over one hundred practitioners, including nurses, who provide EOLC. Religious beliefs were explored through a paper questionnaire, and comfort toward hypothetical clinical scenarios were assessed using a Likert scale. In response to the hypothetical clinical scenarios, nurses were proportionately more in favor of withdrawing and withholding life-sustaining treatments and were against continuation of hydration in EOLC when compared to other evaluated practitioners. Nurses were also much less likely to disagree with providing MAiD. The study demonstrated variability in attitudes and practices in provided EOLC based on personal belief systems that differentiated between the careers of healthcare practitioner respondents. The study also notes a high degree of practice variability related to EOLC provided to patients.[15]

In 2020, a cross- sectional study assessed Saudi nursing students' religiosity and their attitudes towards providing care in which 175 nursing students in Saudi Arabia were surveyed. In this study, it was acknowledged that healthcare policy in Saudi Arabia is highly influenced by Islam faith which may have influenced study results and limit generalizability. Students responded to questions regarding their religiosity

and beliefs regarding provided care on a Likert scale. This study found that the nursing students had a strong relationship between their healthcare attitudes and behaviors, and their religious beliefs. The study also noted a strong relationship between personally identified intrinsic religiosity, and increased frequency of attending religious ceremonies, practices or events. This study, unlike previous, did list implications for practice, such as religious meetings for guidance, and promoting religious conversation and self-reflection with nursing educators.[16]

Croatian study examined the workload perception of 279 nurses at several institutions while providing EOLC and life-sustaining treatments. This cross-sectional study explored a paper questionnaire, shared amongst intensive care, dialysis, and oncology units, where participation was offered to over 300 nurses. The questionnaire gathered personal information regarding participant demographics, attitudes toward life sustaining measures, and religious affiliations. Respondents then rated their perceived workload while providing EOLC. Nurses who were in favor of life-sustaining measures had a higher perceived workload experience when providing EOLC. This study did not propose any recommendations or nursing implications.[17]

In a study with more tangible examples of nursing religiosity and its' effect on provided EOLC, 192 nurses from 117 institutions in Switzerland were surveyed. A qualitative analysis of hypothetical scenarios was completed. These scenarios included questions surrounding death, psychosocial, and emotional, patient and family needs. The results demonstrated a large majority of referrals to religious and spiritual support were completed only in end-of-life scenarios. There was also a noted trend where nurses who endorsed religious affiliation tended to refer patients for religious and spiritual care at increased rates relative to their secular colleagues.[18]

5. Implications for nursing practice

Pertinent literature relating to the topic of religiosity and EOLC are all in agreement that religiosity directly affects nursing care, as well as EOLC care that is provided to patients.[11] This deep-rooted relationship between religiosity and personal identity within nursing is seen as an influence on health and healthcare, influencing nurses' beliefs.[6,8] When the patient's needs and wishes would oppose a nurse's religious beliefs, it can be considered morally and ethically distressing. Religious beliefs and affiliations often require obligation towards concepts relevant to EOLC; these situations may inhibit one's ability to provide acceptable EOLC.[6,8] The literature analysis above demonstrates a more tangible explanation of this phenomenon. In short, religiosity through nursing has a direct impact on patient care, ethical decision making, and provided EOLC.[6,8,18]

EOLC should be provided in a relational manner; relational autonomy and practice variability are required to provide individualized EOLC. What each individual nurse brings with oneself into work will differ based on personhood, however, patients must be provided with equal access in EOLC regardless of practitioner quiddity. This is why religiosities direct influence on patient care and EOLC care calls for recommendations for practice, education, and policy change.

The following proposed recommendations are not for promotion of avoidance in nurses bringing their religiosity to the bedside, this is a part of their personhood and cannot and should not be suppressed. Rather, the recommendations aim to answer the question of how-to bring religiosity to the bedside in such a manner that is most equitable to patients.[8] An initial recommendation is for public acknowledgement regarding the importance and influence of religiosity in nursing care. Once a statement of importance is made, that promotes, and allows for, development of nursing curriculum, policy adjustment, and advanced assessment and interventional tools.[19] Policy changes and implementation of policies surrounding acknowledgement of religiosity and its' influences on providing care, as well as strategies for practitioners to provide unique and patient centered care could work to encourage nurses in upholding these moral obligations.[20] Although important for a bases in creation of curriculum and policy, policies are often inadequate when working alone, we must educate current and incoming nurses in order to provide them with the means to successfully enact policies.[20]

Nursing programs should consider nurses' religiosity and other elements of a nurses' personhood in education surrounding EOLC.[21] Nursing educators in practice, as well as in nursing education should generate awareness regarding religiosity and how to best introduce one's religiosity into their care.[22] It is, in fact, considered imperative that nursing educators continue to explore the need for further teaching surrounding religiosity, amongst other things, so that nurses may meet the needs of their patients.[23] This includes adjustments in curriculum and nursing education, as well as modules or other forms of educating currently practicing nurses, as nurses themselves note a perceived lack of education surrounding the topic.[24] As detailed above, there are well documented interventions exploring solely spirituality in nursing education, but no studies with generalizability were found pertaining to specifically religiosity during the preceding literature review, emphasizing the noted empirical gap. There are several modes of educating nurses surrounding spiritually that should be effective when applied

directly to religiosity, the primary being through educational modules. Educational modules have also been trialed in EOLC for undergraduate nursing students and have demonstrated positive results in the EOLC provided to patients.[25] One study conducted a 2-hour educational module regarding spiritual care for in-patient practicing nurses in the United States. The module was evaluated pre and post through use of a qualitative survey. Interestingly, the first element of this module surrounds proclaiming the importance of the topic on nursing care, similar to the first proposed recommendation mentioned above. The results yielded were that the module was effective in increasing nurses perceived level of comfort with spirituality.[24] A similar study was conducted with 92 nursing students through a quasi-experimental design; the students were assessed with a questionnaire after a spiritual education course was provided. The results demonstrated decreased stress and improved sense of professional commitment after receiving the course, with implications on nursing education being that similar courses should be adapted into standard nursing curricula.[26] Taking these well documented interventions within spirituality and applying them to education pertaining to religiosity should, in theory, improve nurses' confidence regarding bringing this element of their personhood into the workplace, though further exploration of its' effectiveness will be required.

6. Conclusion

In summary, EOLC is highly relevant to nursing care, and identifying and acknowledging factors influencing how this is delivered is of utmost importance. This paper explored religiosity—an all-encompassing term defining a person's public or private involvement in religious groups or activities—as a major factor underpinning practice variability in EOLC among nursing. Further investigations are required to better understand how religiosity influences nursing care, and the effectiveness of the proposed recommendations which include publicly acknowledging the tangible influence of religiosity in EOLC, ensuring that key stakeholders in nursing education—curriculum designers, nursing educators, and hospital administrators—implement continued educational material on religiosity and its' influence on EOLC, and ensuring all nursing staff engage in regular, thoughtful self-reflection on how their beliefs may or may not bias how they provide EOLC to patients. The goal is not to discourage the interplay of religiosity in EOLC, but to ensure patients receive care that most aligns with their values and respects their dignity. In so doing, patients and families may enjoy personalized, equitable, and just EOLC in a healthcare environment that celebrates the rich and deeply personal beliefs of its' nursing practitioners.

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