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Islamic Spiritual Care Through Talqin for ICU Patients With Impaired Consciousness

A Narrative Review

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Abstract

Providing spiritual care to patients with impaired consciousness in intensive care units (ICUs) is complicated by communication limitations, unstable clinical conditions, and unclear professional responsibilities. This narrative review examines the relevance of Hifz al-Din to Islamic spiritual nursing care and proposes an ethically appropriate approach to talqin that can be considered within critical care nursing practice. A focused narrative review was undertaken of publications on critical care nursing, spiritual care, end-of-life support, and the conceptual foundations of Maqashid Sharia, mainly published between 2021 and 2026. The literature highlights the need for individualized spiritual assessment, collaboration with families and religious counselors, nurse competency development, and intervention documentation. Evidence concerning Islamic rituals among critically ill patients supports belief-sensitive care but does not establish that talqin improves consciousness. Accordingly, a conceptual implementation framework was developed covering assessment of religious preferences, appropriate consent processes, clinical coordination, noncoercive facilitation, and process evaluation and documentation. Talqin is presented as spiritual support rather than a substitute for medical therapy or neurological intervention. Field studies are required to assess its feasibility, family acceptance, and procedural appropriateness in ICUs.

Keywords: *Hifz Al-Din, Impaired Consciousness, Intensive Care Unit, Spiritual Nursing Care, Talqin.*

Introduction

Intensive care unit (ICU) services focus on physiological stabilization, close monitoring, and time-sensitive clinical decisions. Nevertheless, intensive medical interventions do not eliminate patients' and families' needs for support related to faith, the meaning of illness, hope, and the experience of life-threatening conditions. Rababa and Al-Sabbah [1] indicated that Islamic spiritual care practices require stronger integration into critical care, while Rustam and Kongsuwan [2] identified several approaches that can be adapted to Islamic principles and practices.

Providing such care becomes more complicated when patients experience impaired consciousness. They may be unable to communicate spiritual needs, directly consent to an intervention, or provide verbal feedback afterward. Inability to communicate must not be interpreted as automatic consent to a particular religious practice. Conversely, disregarding spiritual care may prevent patients' previously expressed wishes from being respected. Research on Spiritual Islamic Nursing Care in Indonesian ICUs has associated the provision of spiritual support with facility readiness, available resources, and service implementation [3].

In Islamic tradition, Hifz al-Din, or protection of religion, is one of the central objectives of Maqashid Sharia. In healthcare, it can be understood as protecting opportunities for patients to practice or receive support consistent with their religious beliefs when this is safe and compatible with their wishes. This perspective does not mean that all Muslim patients must receive the same type of assistance. Asriyani et al. [6] considered the relevance of Maqashid Sharia to critical care, while Akmal et al. [7] discussed protection of religion alongside the protection of life, intellect, lineage, and property as ethical dimensions of nursing care.

Talqin generally refers to prompting or reminding a Muslim of the profession of faith, particularly in circumstances believed to be near the end of life. In a study of scholars' and nurses' views concerning palliative care, talqin and prayers were described as forms of spiritual assistance at the end of life [5]. However, impaired consciousness is not synonymous with impending death. The reason for considering talqin, the patient's preferences, and clinical condition must therefore be assessed separately. Spiritual support must not replace emergency care or other clinically indicated treatment.

ICU nurses occupy an important position because they continuously monitor patients, communicate with relatives, and coordinate with other professionals. Literature on nurses' experiences during the pandemic highlights challenges in providing spiritual care near the end of life [4]. A training study in a palliative care setting reported improved nursing competency after a spiritual care module, although that context and its outcomes differ from talqin delivered to unconscious ICU patients [8]. Direct evidence remains insufficient to conclude that talqin independently improves neurological status or other clinical outcomes in these patients. Studies on general Islamic rituals, Quranic recitation, or family experiences should not be conflated with specific evaluations of talqin. This review therefore synthesizes relevant literature and proposes a Hifz al-Din-based conceptual approach emphasizing ethical appropriateness, patient safety, nursing roles, and interprofessional collaboration.

Materials and Methods

This article is a narrative literature review using thematic-conceptual analysis; it is neither an observational patient study nor an intervention trial. Materials consisted of publications supplied by the authors and checked, where possible, against publisher websites, digital object identifiers, PubMed/PubMed Central, and publication indexes containing research metadata. The review addressed Islamic spiritual care, critical care, Maqashid Sharia, end-of-life support, talqin, and nurses' competencies. Most sources were published between 2021 and 2026; books were used to clarify concepts and care frameworks.

Sources were selected purposively according to relevance to the review questions, publisher credibility, and availability of verifiable information. The search was not designed as a comprehensive search of multiple databases; therefore, no PRISMA flowchart, screening counts, or claims of exhaustive evidence coverage are provided. Empirical studies and research reviews were interpreted in light of their populations, ICU or palliative care setting, actual interventions, and measured outcomes. Research involving murottal, broader Islamic rituals, and talqin was differentiated to avoid unsupported extrapolation.

Information was organized into four themes: (1) spiritual needs and assessment of critically ill patients; (2) Hifz al-Din as an ethical framework; (3) clinical roles and readiness of nurses; and (4) the talqin implementation process with attention to religious preferences, family communication, clinical stability, and documentation. The resulting sequence of implementation steps is a conceptual recommendation, not a validated standard operating procedure or a field-tested intervention.

The review did not recruit patients, access medical records, or deliver interventions, and therefore does not report human research ethics approval. Any contextual photographs would require appropriate copyright permissions and protection of identity. Future field implementation should undergo institutional ethical assessment and obtain applicable permissions and consent.

Findings From the Literature Synthesis

A. Spiritual needs and service gaps

Reviewed sources suggest that spiritual needs arise both among critically ill patients and among relatives facing uncertainty. A study of nurses' ICU experiences described prayer, salat, and dhikr among spiritual care practices [14]. Research examining nurses' knowledge and attitudes also highlighted the relevance of staff capability to meeting patient spiritual needs [9]. Literature involving families of ICU patients further emphasized that spiritual care may require family participation and support [13]. No single ritual was identified as suitable for every patient. A recorded religious affiliation may serve as an initial clue, but individualized assessment should also consider known preferences, customary religious practices, family circumstances, and the patient's neurological status. When the patient cannot consent, family members or legally authorized decision-makers may help communicate previously expressed values without overriding essential clinical safety requirements.

B. Evidence relevant to talqin

Mulyani et al. [5] specifically discussed talqin and prayers as spiritual assistance mentioned by religious scholars in the context of end-of-life care. Their findings describe professional perspectives rather than demonstrating talqin effectiveness among unconscious patients. The phenomenological research of Yusefa et al. [10] explored nurses' experiences of caring for Muslim patients at the end of life in ICUs, highlighting care needs and institutional barriers. A randomized trial by Rustam et al. [11] reported improved comfort following nursing care integrated with daily Islamic rituals among Muslim patients receiving mechanical ventilation. These comfort outcomes cannot be directly transferred to unconscious patients because the intervention, population, and measurement differ. Atrie et al. [12] evaluated Familiar Auditory Sensory Training and murottal among ICU stroke patients; these are not equivalent to talqin in either protocol or study purpose. Together, these sources provide context for belief-sensitive support but do not establish a neurological mechanism or clinical benefit specifically attributable to talqin.

Table 1 summarizes key sources according to their contribution and limitations. It is not intended as a systematic risk-of-bias assessment or ranking of intervention effectiveness.

Table 1. Key literature and limits of applicability

Author	Year	Context and approach	Relevant finding/ interpretation limit
Amal et al. [3]	2021	Implementation of Islamic spiritual nursing care in hospital/ICU contexts	Identifies support needs for resources and implementation; not a talqin trial.
Mulyani et al. [5]	2024	Scholars' and nurses' perspectives on end-of-life care	Recognizes talqin and prayer as spiritual support; does not evaluate unconscious patients.
Rustam et al. [11]	2021	Islamic ritual-integrated comfort care for ventilated Muslim patients	Improved comfort in studied patients; not evidence that talqin changes consciousness.
Abusafia et al. [8]	2024	Spiritual care training module for nurses	Improved competency in a palliative context; not ICU talqin intervention.
Rustam and Kongsuwan [2]	2026	Scoping review of Islamic spiritual nursing methods in critical care	Identifies methods, potential adaptations, and evidence gaps.
Asriyani et al. [6]	2025	Maqashid Sharia in critical care	Supports ethical conceptualization; does not assess talqin effects.

C. A Hifz al-Din-based conceptual implementation framework

The thematic synthesis yielded five practical stages for consideration in service development, shown in Table 2. They are derived from the literature and nursing ethics rather than clinical validation. Before being adopted as an institutional procedure, the framework requires feasibility appraisal with ethics committees, ICU leadership, frontline nurses, and appropriate religious representatives.

Table 2. Conceptual stages of spiritual care and talqin

Stage	Proposed ICU nursing role	Safety and ethical principle
1. Assessment	Review verifiable religious preferences and values; document communication capacity.	Religious affiliation does not constitute automatic consent.
2. Coordination	Consult relatives, clinicians, and religious counselors as appropriate.	Follow applicable professional authority and consent pathways.
3. Situational assessment	Determine suitable timing based on patient condition and clinical priorities.	Do not interfere with resuscitation, monitoring, ventilation, or rest.
4. Facilitation	Arrange brief, calm talqin by an appropriately competent professional or religious counselor.	Voluntary, noncoercive, and consistent with patient preferences.
5. Evaluation	Record delivery, family feedback, barriers, and follow-up.	Do not claim neurological response without valid clinical measurement.

Discussion

A. Hifz al-Din in patient-centered care

Hifz al-Din recognizes that religious needs may remain relevant when a person experiences severe illness. In nursing, however, this principle must be considered alongside Hifz al-Nafs (protection of life), nonmaleficence, and respect for patient autonomy. Akmal et al. [7] discussed several objectives of Maqashid Sharia together; the protection of religion should not be used to justify interventions that compromise patient safety or clinical responsibilities. An Islamic spiritual nursing care textbook provides a broader basis for including spiritual support within holistic care [17]. In the ICU, the key operational questions concern who verifies preferences, when support can be delivered, who is qualified

to facilitate it, how relatives are involved, and what should be documented. Respecting a known prior refusal of ritual assistance is as important as facilitating requested support, even when family members or staff hold different views.

B. Talqin, consciousness, and the limits of evidence

Talqin is a religious reminder, not automatically equivalent to standardized auditory stimulation or neurological therapy. Lack of a verbal response cannot establish that a message was received or that an intervention produced a clinical effect. Evidence concerning murottal or auditory interventions in ICU stroke care [12] has specific study designs and outcomes. Without direct research, it is inappropriate to infer that talqin improves Glasgow Coma Scale scores, oxygen saturation, or mortality. This uncertainty supports further research with clearly defined procedures and outcome measures.

Clinical context must also be differentiated. Conscious Muslim patients may directly express their need for spiritual guidance and report comfort or discomfort. For patients with impaired consciousness, prior statements or family accounts may help establish preferences, but the level of consciousness alone is not a measure of end-of-life prognosis. When relatives request talqin, nurses should clarify the basis of the request and verify that it will not interfere with indicated medical care. Critically ill patients who are expected to recover may also require spiritual support, although that care may differ from end-of-life accompaniment.

C. Nursing readiness and interprofessional cooperation

Knowledge and attitudes relevant to spiritual care are important for service design [9]. Local implementation difficulties [3], ICU nurses' experiences [14], and pandemic-related studies [4] indicate challenges related to time, infrastructure, service routines, and institutional support. Abusafia et al. [8] showed that structured training can enhance nurses' spiritual care competency in a palliative context. Training for ICU nurses could consequently address spiritual assessment, religion-sensitive communication, professional boundaries, documentation, and collaboration with religious counselors rather than focusing only on recitation skills.

No single professional holds sole responsibility for religious knowledge or clinical decisions. Religious counselors may explain or facilitate talqin according to the patient's tradition; family members may provide information about values and preferences; physicians and ICU teams establish clinical safety conditions; and nurses coordinate support within the care process. This approach is consistent with general critical nursing responsibilities [15] and therapeutic communication principles [16].

D. Documentation, evaluation, and policy implications

Documentation should record more than whether talqin took place. Relevant information includes the source of knowledge about patient preferences, the individuals consulted, timing, approximate duration, barriers, and follow-up arrangements. For patients unable to respond, evaluation should prioritize valid process indicators, such as compatibility with the patient's known wishes, procedural safety, and family experience, rather than unverifiable claims about spiritual success or neurological improvement.

The framework in Table 2 may inform the development of a local assessment form or preliminary standard operating procedure. Religion-sensitive spiritual support should be available without

discrimination. A focus on talqin for Muslim patients must not prevent patients of other faiths from receiving appropriate assistance. ICU policies should allow flexible referral, protect the confidentiality of religious information, and avoid unwanted or compulsory rituals. Spiritual support should expand the choices available to patients and families rather than add burdens during critical illness.

Future investigations should initially explore relatives' needs, nurses' experiences, and perspectives of religious counselors and clinicians through qualitative methods. Subsequent feasibility studies could assess acceptability, adherence to patient preferences, nursing workload, operational barriers, and implementation safety. Any investigation of neurological outcomes would require tightly defined procedures, comparison groups, suitable instruments, and clinical eligibility criteria. Without such steps, a well-intentioned religious practice could become difficult to justify as a standardized clinical intervention.

Conclusion

This narrative review suggests that talqin may be considered as spiritual support for Muslim ICU patients with impaired consciousness within the ethical framework of Hifz al-Din, provided that clinical safety, patient preferences, and coordination with relatives and healthcare professionals are respected. The synthesis proposes five conceptual stages: assessment, coordination, situational assessment, facilitation, and documented evaluation. Current evidence does not establish that talqin improves consciousness or other clinical outcomes. Nurse training, locally appropriate guidance, and empirical testing are needed before the proposed framework can be adopted as a clinical standard.

Limitations and Recommendations

Because this was a narrative review, it did not include an exhaustive literature search, formal risk-of-bias assessment, or meta-analysis. Some cited studies concern broader Islamic rituals, murottal, family experiences, or end-of-life care, limiting their direct applicability to talqin among unconscious ICU patients. Separate empirical studies should evaluate feasibility, safety, acceptability, and measurable process outcomes of spiritual care in ICUs.

Conflict of Interest

The authors declare no conflict of interest in this study.

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