

Why Spiritual Care in the Czech Healthcare System?

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Instead of the motto:

What happened last year at one hospital outside Prague: A middle aged female patient with a malignancy was informed that all possibilities of her oncological treatment had been exhausted. She started to cry. Her physician reacted to this by saying: "Mmm ... that's not a big deal, you can reincarnate."

Despite of our cultural denial of the fact, the mortality of human beings is 100%.¹ It is supposed that about 90% of people die from chronic illnesses, i.e. illnesses lasting many months or years. In all cases where treatment does not result in definite recovery (and thus is not curative), it can be described as palliative treatment and care. The World Health Organization defined palliative care in 2002 as follows: "Palliative care represents an approach improving the quality of life of the patients and their families who face the problems related to a life-threatening illness. This goal is achieved by prevention and alleviation of suffering following timely diagnosis, evaluation and treatment of pain and other physical, psychosocial and spiritual difficulties."²

What difficulties do we have in mind when referring to them as "spiritual"? Can we discern them? And – who should evaluate and solve them or, who should help the patients and their loved ones to evaluate and solve them? Are the patients able to verbalize their needs concerning the spiritual dimension? Does a treatment deserve the "lege artis" label if one of its components is being neglected?

These questions are closely related to human dignity, the sense of human existence in general and in the context of illness, the patients' rights, the rights of the dying ones, the truth on a hospital bed and to the problems of interdisciplinary and multiprofessional teams – in other words, to the themes concerning medical ethics.

Let me approach this topic with a small explanatory dictionary. Since spirituality and religiosity were a taboo during the totalitarian regime and the meaning of some words has changed during many years, we don't even have proper Czech equivalents of certain words taken from other languages.

The relationship between the words *spiritual* and *religious* is somehow complex. While *religious* describes pertinence to a certain religion, the meaning of *spiritual* or *spirituality* can be both wider (referring to a general attitude towards some supernatural reality not tied to a concrete religion) and more narrow when representing a certain direction or orientation in a religious system like Christianity.

¹ Levy, M.H., Supportive Oncology – Palliative Care: What's in a Name?, page 132, in: Seminars in Oncology – Supportive Oncology – Palliative Care:2005, Vol 32, No 2, April 2005, W.B.Saunders – Philadelphia, PA

² Doporučení Rec (2003)24 Výboru ministrů Rady Evropy členským státům O organizaci paliativní péče (Recommendation Rec (2003) 24 of the Committee of Ministers to member states on the organization of palliative care) a Příloha k Doporučení (Supplement to the Recommendation), page 22, published by Cesta domů in 2004

Pastoral comes from the Latin *pascere* – to satiate and *pastor* – the protestant or pastoral priest – is derived from the same source. The usage of terms *pastoral care* and *spiritual care* is not unified. Some share the opinion that spiritual care encompasses wider than just religious needs. On the contrary, other authors see *pastoral care* as satisfying spiritual and religious needs at the same time. These authors consider the last mentioned term superior to all others. *Chaplain* is derived from the Latin *capellanus* - a priest tied to a chapel. Nowadays, this is a functional term referring to priests, especially - but not exclusively - to Christian ones. There are five religions of worldwide consequence. Christianity, Judaism and Islam are monotheistic (they share the belief in one personal God and do not accept the idea of reincarnation). Hinduism preaches many gods but above all, there is the Absolute, divine Brahman escaping any definition and a belief in reincarnation. Buddhism is, strictly speaking, not a religion (there is no belief in any supernatural being) but rather a philosophical system leading humans through repeated reincarnations towards nirvana, the state of delight. Our Western culture is rooted in Judaism and Christianity. The hospice movement, too, was inspired by Christian ideas.

I will mention three sources of information pertinent to the question of spiritual care in the healthcare system throughout the world and especially Europe.

1. In 2004, Grada Publishing presented an official translation of the English text “Joint Commission International Accreditation Standards for Hospitals, 2002”:

These standards were created by an international group of experts from all continents (South America and the Caribbean, Asia and Pacific, Middle East, Middle and Eastern Europe, Western Europe and Africa) and represent a basis for accreditation of hospitals throughout the world. The accreditation is considered an effective tool for evaluation and management of the quality of care and the above standards are viewed as optimal and achievable. Standards printed in bold letters are defined as essential. Without their achievement, the accreditation cannot be granted. One of these standards, **PFR. 1.2.1.**, says: **“The hospital has a protocol allowing for satisfaction of the patients’ and their families’ needs concerning spiritual services or similar needs related to patient’s spiritual orientation and religious belief.”**³ ... “The last version of the above document also contains a new section dealing with the care for terminally ill patients and with the management of pain (COP.14 – COP.19). While these standards are not considered essential within the process of accreditation conditions’ fulfillment, the evaluation of pain in all patients (not only those with terminal illness) represents a standard component of the accreditation audits.”⁴

This group of standards speaks repeatedly about spiritual and religious needs and problems, about their detection and management. Spiritual problems of the patients and their loved ones include despair, suffering, the sense of guilt or the need of forgiveness.

In 2003, the Czech hospice movement *Cesta domů* (“the Homeward Journey“) published a Czech translation of “Recommendation Rec (2003) 24 of the Committee of Ministers to member states on the organization of palliative care” (“Doporučení Rec (2003)24 Výboru ministrů rady Evropy členským státům o organizaci paliativní péče” a “Příloha k Doporučení”). One of the reasons why this material is highly relevant to the spiritual care in the healthcare system is represented by the fact that it uses the term “spiritual“ 22 times. It is usually followed by nouns such as: questions, needs, difficulties, suffering, problems, well-being, support, care, aspect of care and comfort. Beside that, the existential issues are mentioned twice. Altogether, the document touches the same topic 24 times. Just one citation

³ Mezinárodní akreditační standardy pro nemocnice (International Accreditation Standards for Hospitals), page 44

⁴ The cited work, page 137

as an illustrative example: “Palliative care consists of psychological and spiritual aspects of care for the patient. High-level interest in physical well-being of the individual is, of course, essential but not satisfactory on its own. We must not reduce any human being to a mere biological unit.”⁵ In this context, it is necessary to repeat that palliative care is not synonymous to terminal care (which it encompasses, however) and that the goal of palliative care is to reach the optimal quality of life the patients and their families can achieve. The major dimensions of palliative care are thus as follows:

- alleviation of symptoms
- psychological, spiritual and emotional support
- support provided to the family
- help offered to the family while mourning⁶

3. The European Network of Chaplain Services in Healthcare adopted the Standards of Healthcare Chaplain Services in Europe in 2002. The English text can be found at www.eurochaplains.org.

To date, there is no unified translation of the term *healthcare chaplaincy* in Czech language; it can be expressed in various ways: *zdravotní kaplanství*, *kaplanská služba ve zdravotnictví*, *klinická pastorační péče* či *nemocniční pastorační (duchovní) péče*.

The Standards define healthcare chaplaincy as a service - respecting the existential, spiritual and religious needs of those who suffer and those who care for them - bringing people towards the sources of their personal and cultural identity, belief and community.

Various surveys came to the conclusion that the citizens of the Czech Republic are one of the most atheistic people in the world. We may thus pose a question whether it makes any sense to consider a widespread introduction of spiritual care in the healthcare system while its financial support⁷ is clearly insufficient and the need for spiritual care can be viewed as uncertain, maybe even useless. Do we really differ that much from the rest of this planet's population? Do we, Czechs, have any spiritual needs at all? And what spiritual needs do people have in other countries of the world? The fact that the need for spiritual care found its way into the palliative medicine as such and among the worldwide standards of hospital care cannot be easily neglected.

People often try to touch the transcendental sphere or God even when banal issues are at stake. How much more profound must this desire become in so called borderline situations, e.g. when facing a life-threatening illness? Philosophy poses a number of questions in this context and provides an immense amount of answers to them, often contradicting each other. “Sometimes they speak about a *philosophical scandal*. This term refers to the fact that while specialized sciences show great progress and reach their victories, philosophy is just a mere confusion and disappointment.”⁸

Despite this statement, we have to review briefly what some philosophers have to say when it comes to questions such as “*What is a man?*”, “*What is death?*”, “*How should we face death?*”, “*Is there a hope for a man beyond the scope of death?*” etc.

The Greeks described a man as *zoón logon echon* – a living being with a logos. *Logos* has several meanings including *word*, *reason*, *spirit* but also *sense*. The above combination of

⁵ Doporučení Rec (2003)24 Výboru ministrů Rady Evropy (Recommendation Rec (2003) 24 of the European Council Committee of Ministers), page 23

⁶ See also the cited work, page 10

⁷ In Europe, healthcare chaplaincy is usually funded by multiple sources including both the state and the churches. My service is financed by the Catholic church – having a half-time job, I earn 5000,- CZK.

⁸ Anzenbacher, A. Úvod do filosofie (Introduction to Philosophy), Logos Praha 1989, page 39

words was translated to Latin as *animal rationale* – rational animal. The animality of a man is characterized by its carnality, finality and necessity as well. The other human pole is usually referred to as transcendentality, “spirit”, consciousness of the self, Ego. The typical features of this pole are, for instance, freedom and orientation towards the future. “On one hand, spirit is our true Self (Aristotle) while on the other, we enter the worldly light between the stools and urine (*inter feces et urinam* – Augustin). Yet still the human personality is formed by both of these aspects.”⁹ By developing the theme of personality, some philosophers (Buber and others) reached the conclusion that a man only becomes a personality through a relationship towards another man or God. “It is solely in a living relationship when you can fully appreciate the being of a human, typical just of himself. Gorilla is also an individual, the state of termites is a collective, but Me and You only exist in our world because there is a man, Me being formed by a relationship towards You.”¹⁰

“An integral part of human authenticity is a capability to *face one’s life as being towards death*; not to ... avoid this fact in one’s active worldly life but to accept firmly it as a possibility. A man being deceived by uncertainty demonstrates avoidance when refusing to say ‘I will die’, saying ‘people die’ instead – and he does not seem to be involved any more.”¹¹ Nevertheless, “death is still present at every moment, no matter how suppressed ... human existence is always projected and lived on the horizon formed by the knowledge of death. Death is a question in human life and it poses this question to the life itself.”¹²

These thoughts and statements lead towards questioning about the very sense of human existence, a problem shared by philosophy, psychology (e.g. Frankl) and religion. As for the question of sense – we may say from the philosophical point of view that besides partial goals and values (interpersonal relationships, health but also a classless society preached by Marx and Engels or fulfillment of a longing for power in *der Übermensch*, “the superman” mentioned by Nietzsche), a man also recognizes a sense of human existence in general. The philosophical awareness of the sense (i.e. the human ability to appreciate it) of the entire human existence enables a man to find an order and coherence within the partial goals. Here, however, philosophy reaches its border formed by two basic alternatives – either faith (inspired by a need to explain suffering, failure and death) or the critique of faith or religion; the latter speaking only of the partial aspects of human life and being unable to reach any general conclusion concerning sense. “The dialogue between the certainty of faith and the critique of religion is an eternal challenge in which philosophy is assigned the leading part.”¹³

Viktor E. Frankl, a psychiatrist, devoted his entire life to the question of sense. This founder of logotherapy reached a similar conclusion as philosophy by psychotherapeutic means. He also spoke of a last or higher sense (“yet not with anything supernatural in mind”¹⁴) in which “we only can believe”.¹⁵ This sense thus lies beyond the scope of our rational thought. As a psychiatrist, he drew a sharp line between psychotherapy – a science about mental health – and theology – teachings about salvation of the soul.¹⁶ Being also a Jew who survived the internation in several concentration camps, he wrote the following as well: “A statement *Amo (Deum) ergo (Deus) est / I love (God), so he (God) exists* is no more no less convincing than the statement *Cogito, ergo sum / I think so I exist*. While the latter sentence ‘derives’ the ego as a subject from the act of thinking, the former ‘derives’ God as an (infinite) object from the

⁹ The cited work, page 189

¹⁰ Buber, M. *Problém člověka* (The Way of Man), Kalich, Praha 1997, page 153

¹¹ The cited work, page 198

¹² Scherer, G. *Smrt jako filosofický problém* (Death as a Philosophical Problem), page 12

¹³ Anzenbacher, A. *Úvod do filosofie* (Introduction to Philosophy), Logos Praha 1989, page 295

¹⁴ Frankl, V.E., *Co v mých knihách není* (What Is Not in My Books), page 43

¹⁵ Frankl, V.E., *Co v mých knihách není* (What Is Not in My Books), page 43

¹⁶ See also the cited work, page 43

act of infinite love.” ... **“The personal God sought by a religious man is nothing else but a kind of primeval You, after all. Yes, this is so much and so deeply true that it is entirely impossible to speak of Him; one always has to speak to Him.** And I do not know whether a man who ... was in a concentration camp, stood in a grave and spoke to God can ever after in his life stand in an auditorium like this and speak **about** God as about the same being to whom he spoke a long time ago in the grave ...”¹⁷

Not only great philosophers but also any man who faces a life-threatening illness deals with questions like *What is death? Is there a hope beyond the border of death? What is the sense of death? What is the sense of life “in the shadow of death”?* Feelings of despair and suffering, destruction, missing fulfillment of life but also a longing for the transcendental, for God, volatile “temptation” to think of God in the same manner as if we stood on the seashore or on a high mountain, the need to pray, to forgive, to find and embrace the sense of our own life are one of the basic spiritual needs of an ill person.

Why? Why me? Thanks God it’s me and not my child or my relative! ... All these questions are preceded by an exclamation universal to almost all people, no matter their faith or religion: *Lord! My God! What happened?! No, this is not true!* According to dr. Kübler-Ross, we are in the phase of shock and negation. It represents a kind of instinctive turn towards transcendental or towards a personal God. Later on, the patients – the so called non-believers earlier than others – are “tempted” to contemplate their fate or God and to pose many other questions. Existential thoughts or problems accompany them throughout their illness ever after, become more intense during crises and by the time their illness comes to its end. These human needs and emotions do not entitle us to conclude that transcendental (the Sense, God), the object of human desire, exists. It is, however, necessary to accept the fact that men have a spiritual dimension and that spiritual and religious problems become almost palpable under certain circumstances.

If we seek the roots of the current spiritual care in healthcare systems, we must return to a rather remote history.

A group of nomads, lead by Abraham according to the Bible, left ancient Mesopotamia and headed towards the Near East. Because the life conditions were disconsolate, a part of the tribes went to Egypt. The Israelites were enslaved there but thanks to a mighty God’s interference in which both the Judaism and Christianity believe, they were relieved of the slavery later and taken to the “Promised Land”. The entire Old Testament presents God as someone who saves men, takes them out of servitude and cares for them. Since the peasant culture of that time understood the image of a shepherd easily, a metaphor of a shepherd – among others – was adopted for the loving and protecting God. Psalm 23 (the oldest psalm texts were composed approximately 3 thousands of years ago) says: *The LORD is my shepherd; there is nothing I lack. In green pastures you let me graze; to safe waters you lead me; you restore my strength. You guide me along the right path for the sake of your name. Even when I walk through a dark valley, I fear no harm for you are at my side; your rod and staff give me courage.*¹⁸ Some readers may note in this context that these verses were set to music by A. Dvořák.

In Christianity, the above view was confirmed and further elaborated. Jesus says about himself in St. John’s Gospel: “I am a good shepherd. A good shepherd is prepared to lay down his life for his sheep.”¹⁹

¹⁷ Frankl, V.E., *Vůle ke smyslu* (The Will to Meaning), page 48

¹⁸ Bible, Psalm 23, 2-4a

¹⁹ Bible, St. John: 10, 11

It is also necessary to mention the 25th chapter of St. Matthew's Gospel where Jesus identifies himself with the hungry and thirsty ... and with the ill ones, too.

St. Luke's Gospel contains the story of the Good Samaritan²⁰: A man is attacked, robbed and left to die by the side of a road. Two people passing by avoid him but then a compassionate Samaritan (an enemy, in fact) immediately renders assistance by giving him first aid and taking him to an inn to recover. Jesus encourages people to act in the same way.

One can say with some exaggeration that the inn where the Good Samaritan brought the wounded man became the first hospice or a hospital.

The way how New Testament deals with the ill ones can be demonstrated by several verses by James, speaking of a prayer for the ill. This text forms a basis of the so called Anointing of the Sick practiced in the Catholic Church.

Inspired by the above texts, the Christians begun to care very intensely about the ill and handicapped. Where does the word chaplain or a hospital chaplain come from?

Beside dressing of the wounds and healing of the illnesses, prayer, reading from the Bible and the sacraments – in other words, pastoral care – formed an integral part of care for many centuries. It used to mean and it still means today to act like Jesus, the good shepherd satiating with good things – with the word (the Bible) and the flesh (the Eucharist). This care has been reserved for centuries to the priests and pastors.

According to the Code of Canon Law expressing the views of the Catholic church, "Chaplain is a member of the clergy entrusted to provide a long-term pastoral care (at least partially) to a certain community or a special group of Christians."²¹ A special group of Christians may consist of Christians in hospitals, in the army or in prisons. However, the word chaplain is also used by protestant churches. The ecumenical cooperation of the Christian churches in the 20th century led to a certain change of its meaning. In Western countries, this term currently refers to a person, either man or a woman (a woman cannot become a priest in the Catholic church), with an appropriate university education and an authorization by his or her church to provide a pastoral care in hospitals. Many countries also require that the hospital chaplains go through a special postgraduate education (CPE – clinical pastoral education) or training (CPT – clinical pastoral training).

Spiritual care for the ill is thus rooted in Christianity. During the last century, Jewish chaplains also appeared. Even the Muslims started to show interest in this kind of service lately despite the fact that it is not a part of their religious tradition.

The characteristics of pastoral care can be summed as follows:

- 1. care with respect to the needs:**
 - existential
 - spiritual
 - religious
- 2. seeking the sources and bringing people towards them:**
 - personal
 - concerning faith
 - cultural
 - concerning community
- 3. individual approach**

A hospital chaplain has to defend the immense value and dignity of every person. His or her presence at the ward provides the suffering with yet another dimension which most people do not commonly recognize. He or she should also make sure that spiritual needs of people

²⁰ Bible, St. Luke: 10, 25-37

²¹ Code of Canon Law, canon 564, page 261

belonging to different religions and cultures are satisfied and should protect them from unwelcome spiritual obtrusiveness (of sects, for example) or from proselytism (other religions' attempts to convert people to their beliefs).

A case from my experience: A female patient diagnosed with malignant melanoma makes haste to claim that she would undergo any kind of treatment except for blood transfusion. In a dialogue she confirms being a Jehovah Witness. She was baptized as a Catholic and lived for many years as such. Since she has no close relatives and is attached very firmly to the social network of the Witnesses, it is essential for her to retain this latter decision, faith and anchorage. We got on very well together and the patient has been very grateful to me for respecting her freedom.

The chaplain should provide (or arrange) services, ceremonies and sacraments of a given religious tradition. There are relatively few practicing Christians (attending church services regularly) or Christians with an intrinsic faith among my patients (0 to 3 at an oncology department with 20 beds). These people are usually interested (when they are Catholics) in obtaining the Eucharist or possibly other sacraments. The Catholics and Christians of other denominations also appreciate reading of Biblical texts, prayers and discussions.

Listening represents the basic "tool" the chaplain can use not only when meeting the believers but especially when facing people with an external form of faith, residual faith or no faith at all. It has been astonishing me for many years how many people feel the urge to relate their life story – often as soon as during our first encounter. There are several possible explanations. People want to belong somewhere from the social point of view – even in the hospital. The patients need to organize their thoughts and tell someone that their life was and still is important. They often try to justify their failures or seek forgiveness. They want to either find or confirm the sense of their life. Intuitively, they need to cope with the past to be able to face the future.

An elderly lady starts to tell me about her life before I manage to sit next to her bed. Listening patiently and in silence even to things that seem to be of no consequence, I gradually understand why. She has been living for decades with a remorse that she did not give a chance to be born to a child that would have been my age nowadays. She eventually expresses her previously suppressed pity and her need of forgiveness.

A former frontier guard at our Western border keeps telling me over and over again how creditable his work was and he defends his communist party membership. I simply listen without expressing any judgements. The treatment is very demanding and leads to severe complications. The patient thinks that he would die. I am sitting by his bed, holding his hand. He starts to tell me in a soft voice that he has been baptized, used to serve as a ministrant and got married in a church. Reading the Psalms brings him to prayer ...

A young woman, mother of two small children, met a group of Christians before being diagnosed with her illness; during treatment, she encounters the Buddhists and the New Age literature as well. She does not know what to choose. I recommend that she chooses whatever she finds the most intimate, "her cup of tea". One day she awaits the results of her CT scan and seems to be very anxious; I sit next to her. She is holding something in her clenched fist. After several moments elapse, I ask her: "Can you please show me what you have in your hand?" She opens the fist, revealing a cross.

The hospital chaplain should be a part of a multidisciplinary team. This position has got its major advantages: when s/he enters the hospital, everyone knows that s/he belongs to the ward and the patients are used to his or her presence. S/he does not come just like a person who eventually leaves and who simply came for a moment after being summoned. On the

contrary, s/he takes part in the suffering of people sharing the deck of one ship, one submarine. S/he takes part in their little pleasures but more importantly, is there with them and for them when they are anxious, seeking and posing questions. S/he shares their pain when a fellow-patient dies on the ward or in their very room.

Like the other members of the team, s/he is viewed as someone who is supposed to help. This fact alone evokes the atmosphere of trust. S/he is available to all patients while their abilities to communicate often fluctuate in a fast manner during the hospitalization. S/he can respond to their situations and needs more readily. The patient, of course, has a right to refuse the contact with a chaplain.

Repeated hospitalizations make it possible to reassume the previous dialogues and to elaborate them:

I do not believe, I have no relationship towards Christianity at all. I respect this message and understand the great pain this lady has to endure – she was still teaching several days ago and the test results from the previous month were negative. A sudden flare of the illness came, however, and changed this woman full of life into a patient confined to bed within a few days. I come to see her every day to say hello and to hand this or that to her on demand, to open or close the window, etc. After a spinal surgery, the lady is transferred back to our department. Another female patient dies in the room on that day. *Pray for me, doctor. I pray for all of us.* Suddenly – *Will you pray with me?* To my great surprise, she knows the Lord's Prayer by heart.

The urge to pray is one of the strongest spiritual needs. At the same time, it is very intimate – people usually speak of it only in the atmosphere of understanding and when they fully trust the partner in whom they confide. Etty Hillesum, a Jewish girl, went through a process of maturation all the way from an atheist to a deeply religious person. Her life came to its end in Auschwitz. Her diaries document her spiritual growth.²² Among other things, she says: "... I will always retain my clasped hands and bent knees. These gestures did not pass from one generation to another among us Jews. I had to learn them myself. They are my most valuable heritage ... my most intimate gestures, more intimate than any gestures of an amorous relationship with a man."

Despite the fact that some patients have no ties to any religion altogether, they still have their spiritual needs. They want to complete their life, to repose and feel safe. One patient – a dustman – also tells me his life story, how he grew tomatoes and flowers in the porch ... When I see him for the last time, he asks me to arrange his pillow. *Thank you*, that's all he manages to say then; a weak smile followed by a peaceful expression appears on his face and he loses his consciousness.

The chaplains worldwide also take part in teaching programs for healthcare professionals and in research programs concerning spiritual care.

I am very grateful for the opportunity given to me by the journal *Diagnóza* (Diagnosis) to present the theme of spiritual / pastoral care. To date, this topic was almost unknown to both healthcare professionals and to the patients. Not only the pressure exerted by the European Union but also stories resembling the short case mentioned at the beginning of this article should make us reconsider whether a very important part of the care for gravely ill is not neglected in our country. Ignorance combined with attempts to provide the "first aid" in this domain can do more harm to the patient than we can possibly imagine. Even this type of care, like the other ones, should be entrusted to an expert.

²² Hillesum, E. *Přervaný život – Deníky E.H. (An Interrupted Life – the Diaries of EH) 1941 - 1943*

