

Panagiotis Pentaris

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The Journal of Education, Culture and Society nr 1, 38-43

2013

Artykuł został opracowany do udostępnienia w internecie przez Muzeum Historii Polski w ramach prac podejmowanych na rzecz zapewnienia otwartego, powszechnego i trwałego dostępu do polskiego dorobku naukowego i kulturalnego. Artykuł jest umieszczony w kolekcji cyfrowej bazhum.muzhp.pl, gromadzącej zawartość polskich czasopism humanistycznych i społecznych.

Tekst jest udostępniony do wykorzystania w ramach dozwolonego użytku.

PANAGIOTIS PENTARIS
p.pentaris@gold.ac.uk
University of London, England

HEALTH CARE PRACTITIONERS AND DYING PATIENTS

ABSTRACT

A full understanding of and a competent approach to dying patients may lead to a more qualitative service delivery, an enhanced quality of life paradigms, and the patients' well-being, all of which remain the ultimate goal of health care practice. The modern world has developed in parallel with secularism and religious diversity. This paper aims to illustrate the secularization process in Britain (with indications of generalized meanings) and juxtaposes it with a description of the needs of dying patients regarding the meanings of religion and non-religion. Although this paper draws on and provides a review of selected theoretical literature, it also addresses a significant challenge: the lack of scientific research on the subject. Hence, this paper aims to give an overview of the issues, but not synthesise them. The arguments that are elaborated in the paper are also supported by the author's current research project in the city of London.

The approach here is client oriented, and concerns social and health care. Practitioners ought to become competent, and maintain their competence throughout their professional career. Religious competence seems to have not been at the centre of discussions, regardless of the historical pathway that religious discourse has drawn since the beginnings of humanity. The paper concludes with certain suggestions for future research and inclusive approaches regarding religious matters.

Key words: secularization, thanatology, religion, UK, health care practice, dying patient

INTRODUCTION

Working with the dying is a unique practice, which requires one to possess a unique knowledge, skills and competencies. As Dame Cicely Saunders (2005) suggests, the dying are the only ones who know how to die, based on their own unique character, personality, and background. A determinant parameter of health care practice with the dying is cultural competence, as it has been noted by numerous authors (Canda & Furman, 2010; Belshaw, 2005), researchers (Pentaris, n.d.; Campione, 2004; de Hennezel, 2007; Byock, 2002) and local authority bodies (IFSW, NASW, NHS, NIH, DoH-UK)⁵.

This paper attempts to distinguish cultural competence from a religious determinant (the latter according to the author's own definition). Today's Western world

⁵ International Federation of Social Workers (IFSW); National Association of Social Workers (NASW); National Health System (NHS); National Institute for Health (NIH); Department of Health – United Kingdom (DoH-UK).

thrives in a secular context that excludes faith issues from the public space, and keeps religious matters in the private sphere (Dinham, 2012, 2009). Within a given secular context, health care practice, and, by extension, the practice of working with the dying, is driven by aspects that have nothing to do with the fact that death is experienced through religious and/or non religious beliefs, and vice versa.

Health care practice embraces values and principles that play a central role in creating the clients' well-being. The latter may not only include individuals, but also family systems, larger groups, or a whole society. Some of the core principles include the following.

- Protecting the rights and promoting the interest of service users. It is important to treat each person as an individual, promote their worldview and the importance of their wishes in care; respect their unique personality and character, support their independence and provide informed choices; maintain their dignity and privacy, as well as respect diversity and provide fair and equal opportunities.
- Establish and maintain rapport: health care practitioners ought to be honest and trustworthy in relations with their service users, as well as respectful and reliable. They should also explain clearly all the policies and services, and justify arrangements and commitments. Also, it is important to spot conflicts of interest and follow rules and norms that are effective within an organization and system.
- Promoting independence: provide a full understanding of the rights of service users, and how those rights can be used to guarantee independence of users; challenge behaviours only to promote independence but not to cause any harms (physical or psychosocial); provide a safe environment for the practice to take place.
- Respect the rights of service users, in particular to recognise the right of service users to take risks and support them in their decisions of taking them, follow necessary risk assessment policies, and minimize potential harm.
- Uphold public trust and confidence.
- Promote and maintain quality work and quality health care practice by embracing the diversity of service users, and putting a strengths perspective into practice.

Much more values and principles characterize the work with dying patients in the health care sector. Prior to any discussion on the challenges that the current diverse environment highlights to thanatology (otherwise known as the science of death), it is crucial to look at the scientific aspects of it and understand what the work with dying patients entails.

DYING PATIENTS

Death, dying and bereavement constitute different and individual experiences: they are unique processes for every person, not only because each of us have different personalities, coping skills and coping mechanisms, but also because these events in life are unique experiences of loss. No experience can be the same as the previous one.

The factors of culture and religion play a critical role in how people perceive and deal with death, dying and bereavement. Every culture and/or religion is unique and holds different and authentic beliefs and customs on these subjects. Some of

them depend on the level of spirituality; others depend on family structures, and etc. Hence, even though death and bereavement are individual experiences, cultural and religious backgrounds can make those processes more complex and unique, since there are different approaches to the concept of loss. Having said that, there is a need for care giving professionals to increase their awareness, enhance their competence and increase their effectiveness at work.

Dying people are struggling with several losses at the same time. Among other things, they suffer from the loss of their individuality and the loss of opportunities for future experiences. At this point in one's life, it is understandable and expected that the process of making construction takes place. The dying patient will seek for comfort by making sense of death and by wondering what it means to come to an end (Pentaris, n.d.; Byock, 2002; Kübler-Ross, 1969; Feifel, 1959). Thanatological practices and service delivery by health care practitioners are to be planned through sensitive-based practices and inclusive characteristics. Religion is one of the nine strands in the UK that refers to equality and diversity. Religious diversity in the UK is growing (Meister, 2011), while at the same time secularity is becoming more intense and religious identities more private, or even absent.

RELIGIOUS IDENTITIES AND A SECULAR SOCIETY

Contemporary societies have already gone through a separation of politics and faith. The main religion of Britain is Anglicanism. However, Protestants and Pentecostals thrive as well. Religious history in Britain is part of its social history and politics as well (Prochaska, 2006). Britain exemplifies a multi-religious environment, especially after the immigration flow became more intense since the mid 20th century (Norris, 2011). Based on the UK Census 2011, Christianity still remains the dominant denomination in Britain (59%), as well in Wales, despite the significant decline of 13 percentage points since the Census 2001 (72%). In 2011, 25 % of respondents stated they had no religion, which stands in stark contrast with 15% in 2001. The third in line was Islam with 15% respondents identifying with this denomination.

The question regarding religion in the Census has been introduced only recently and is voluntary. Hence, it is not certain whether the statistics depict the whole population's religious orientation or not. Nonetheless, it is a bit surprising how the number of people feeling affinity with any religion has declined. Historians and sociologists attempt to envisage future trends of religious connections and belonging, and their estimates show that there will be a significant increase of Islam affiliations in the future, since Muslims are a large category of immigrants in Britain, which constantly grows (Norris, 2011; Meister, 2011). Woodhead and Catto (2012) have captured religious changes in contemporary Britain, focusing on the dominant religion, that is, Christianity. Even though Christianity, and especially Anglicanism, is one of core religious practices within Britain, other so-called "minority" religions co-exist and intersect with the dominant one.

The most noticeable religious minorities in Britain are Judaism, Sikhism, Islam, Hinduism and Buddhism (Woodhead & Catto, 2012). All these religions mainly "travelled" to Britain together with immigrants from outside the UK. When a re-

ligion “migrates”, there are lots of parameters that need to be taken into consideration. A religion is not simply transferred through believers to a different nation. It undergoes several changes and it is then adapted to the societal, political and environmental circumstances of the nation it migrates to. “Religions change as they travel, and so do those who live by them” (Woodhead & Catto, 2012, p. 86). In addition, the dominant religion (in this case, Christianity) of the location one migrates also undergoes changes and is adjusted to the new religious affiliations in its environment and to the impact those new religions exert. This entails a whole process of inter- and intra-communication among faith groups and belief systems, in order to use the opportunity for religious competency within a multi-faith and multi-religious society. If we view secularization as a reaction to those changes and the religious diversity that has occurred in Britain, then religion has been privatized (Woodhead & Catto, 2012) due to feelings of inclusion and respect for the diversity that characterizes the nation. Secularization means as the process of becoming more secular, which is characteristic of and defines British society today.

Secular beliefs stress the importance of being equal and fair within a diverse environment⁶. It is the outcome of a complicated process of religious mix in contemporary Britain. It also indicates a critical role to the non political status that religion has in a modern or post-modern society (Bruce, 2011).

It was after the 1990s (Woodhead & Catto, 2012) that the concept of desecularization was introduced (Berger, 1999), which can be understood as a reaction against secularization and a de-privatization of religious matters. Desecularization proposes to bring religion back to the public sphere.

The differences and the contradiction between the two trends (secularization and desecularization) that have a great impact on Britain today aside, there are still high secular beliefs rates (UK Census, 2011) and religious matters divert from public spaces (Woodhead & Catto, 2012; Meister, 2011; Erdozein, 2012; Prochaska, 2006).

THANATOLOGICAL PRACTICES: THE SECULAR AND THE RELIGIOUS

Thanatological practices encompass health care practices in a wide range of settings, such as hospices, hospital wings, nursing homes, elderly homes, pastoral care settings, etc. However, a practitioner might be assigned to work with a dying patient in other settings as well, such as a charity. Health care practitioners, including general practitioners, nurses, psychologists or social workers need to find themselves competent enough before engaging in work with the dying.

The role of faith (and, by extension, religion) in the public space has a significant impact on several societal levels of social policy and practice, including health care practice. At present we are experiencing the process of secularization of westernized and globalized society (Meister, 2011). Hence, professional practitioners in health care are driven by ideas, values, and principles of the privatized context of religion and faith

⁶ Also refer to Dinham and Jones (2010) with their work on the Religious Literacy Leadership Programme (RLLP). The programme was initiated in 2009 due to the complicated religious issues that arose in the Higher Education Institutions (HEIs) in the last few decades, which emerged due to religious diversity within HEIs.

issues. No matter how widely recognized inter-faith and multi-faith issues have been in the UK (Woodhead & Catto, 2012), professional practitioners are still offering services in a secular manner, keeping religion outside (de Hennezel, 2007) of thanatological practice. The latter tendency bears witness to the absence of recognition of certain needs by dying patients, and effective assessment on the professional practice and services.

Secularization has sidelined religion and taken it out of public discussion (Dinham, 2009). It is nowadays (in the UK and other nations as well) not politically correct to talk about religion publicly, whereas public displays of religious rituals are acceptable while they are not named as such (Norris, 2011).

The main controversy of this conversation lies in the still existing and underlined religious identity of the members of contemporary secular society. People remain religious to a large extent, and that brings us to the challenges that professional and health care practitioners may and are facing in the thanatological practice. As mentioned earlier, death is an experience often viewed through a religious lens, while religion is also experienced through death. It is the dying process that elicits certain and additional needs in the individual. While moving towards imminent death, a need for hope arises and the individual, as well as his/her family, tends to turn to religion (Alexander & Adlerstein, 1959), regardless of whether they have been religious during their lifetime or not. There is a tendency that people become religious or enhance religious beliefs towards the end of life (Belshaw, 2008; Byock, 2002; Aries, 1974). Based on that tendency, challenges in health care practice become obvious, as secularity “disagrees” with the public conversation of religion, and, to that extent, secular professionals tend to ignore religious matters in their delivery of care service.

CONCLUSIONS

In her study, Elizabeth Kübler-Ross interviewed dying patients. Her project was aimed at understanding such terminal patients made sense of their experiences, through what dimensions they constructed that meaning, and how they processed it. In her very long discussions over the years, and her past research, she has highlighted, among others, the religious factor in the dying person's life. People resort to religion in order to construct meanings of things they cannot otherwise understand, such as death. Of course, this seems to be a generalization, however, there are exceptions, such as atheists, who believe that death is only the end of a process.

Religious identities of service users in thanatological settings contradict the secular character of British society and also the secular manner in which health care practitioners offer services. British society has privatized religious matters and has banished all the religious interpretations of public displays of rituals to the margins. Health care practitioners in the UK today are driven by secularism and the value that religion is a very sensitive matter that needs to remain private.

At the moment of death, when everything in a person's life is coming to an end, and a sense of hope is the only thing needed, religion is crucial in restoring that hope. It is at this point that the dying individual seeks for compassion and understanding through belief systems and values, and in collaboration with the professional practitioner (de Hennezel, 2007; Pentaris, n.d.).

Religious competence and de-secularized contexts in health care practice seem necessary in the UK these days, for secularization negatively affects the practitioner-service user relationship and makes the establishment of rapport more difficult. Acceptance of the differences and the recognition of religious matters in the health care setting may increase the effectiveness and efficiency of those working with dying patients.

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