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FULFILMENT OF SPIRITUAL AND RELIGIOUS NEEDS IN MODERN HEALTHCARE IN CENTRAL AND EASTERN EUROPE

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Abstract. *Health services and their institutions are rarely seen as places where "soft" cultural matters have importance. The classical European paradigm of evidence-based medicine perceives human beings from a biological rather than a spiritual perspective. However, challenges in contemporary Europe (and also in the whole world) show us that we cannot ignore religious differences in any kinds of public spaces. Eastern European countries have lost their monoreligious character, and there is a growing number of patients from different cultures and religious traditions. Western European countries that face mass refugee movements also need to adapt their health services to the religious demands of both foreign and domestic patients (including those with acquired citizenship). It is a significant challenge*

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to the legal system as well, with a growing need for structural and systemic solutions. The academic education of future health service specialists should, meanwhile, be adjusted in line with these factors and include more courses on interreligious communication, bearing in mind the lack of proper handbooks for these professions in the Eastern European area at least.

Keywords*: public spaces, healthcare system, religion, intercultural dialogue, interreligious dialogue*

Introduction: interreligious dialogue in healthcare

Healthcare is not usually associated with religion or spirituality, though maybe sometimes on the more abstract level of "spiritual healing" or in connection with healers from traditional cultures or biotherapists who base their healing on a specific set of religious beliefs. It is evident that more and more patients from various cultural backgrounds and with different religious beliefs nowadays visit hospitals, health centres and pharmacies in countries that up until now were largely monoreligious and monocultural. According to the UN[1], the number of migrants reached almost 250 million in 2015 (71 million more than in 2000). In 2012, one in 35 people in the world was a migrant, living and working outside their country of origin. In this context, intercultural and interreligious encounters are statistically inevitable.

The needs of patients arising from their religious beliefs can have a serious impact on healthcare practices, especially those of hospitals. This may be connected to special dietary requirements (such as forbidden products or a kosher diet); necessity or an inability to undergo specific treatments or therapies (such as transfusions, gynaecological treatments or circumcision), or to take certain medicines; the necessity of performing religious practices at specific times (for example, prayers, periods of isolation or fasts) or contacting a religious guru or priest; prohibitions linked to contact with people of the opposite sex, either before or during procedures; obligations and prohibitions connected with certain procedures, such as labour practices in various traditions; post-surgery procedures (such as post-labour procedures and those linked to stillborn babies and the placenta); and the anointing of the sick. It is impossible to create a definitive list of all possible issues that could emerge during treatment. Various religious denominations may approach the same health or disease situations with different attitudes, which could be even more diversified in the case of some orthodox believers (such as in the case of orthodox and reformed Jews).

Alongside the growing influx of people from developing countries into Europe, the mobility of doctors and nurses from other countries also increases. Many authors highlight that this proves problematic for countries from which healthcare professionals emigrate, damaging the health services in the source countries[2]. In Zimbabwe, for

1 UN Department of Economic and Social Affairs (accessed 2018.01.06) http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates15.shtml

2 Watkins S., Migration of healthcare professionals: practical and ethical considerations, *Clinical Medicine*, Vol 5 No 3 May/June 2005, p. 240-243.

example, only 360 of 1200 medical school graduates between 1996 and 2004 stayed. In a situation in which many of medical professionals are migrants considered to be from a religious or ethnic minority, patients that belong to minority groups do not present as much of a challenge as in countries such as those in Central and Eastern Europe, where most medical personnel belong to the dominating monoculture. Patients from different cultural and religious backgrounds may prove problematic for medical staff, especially when they express their needs and beliefs. As a result, the distinction between religious needs (stemming from belonging to a particular religion) and spiritual needs (connected with values, views and spirituality, and not necessarily with belonging to a certain religious belief system) gains a completely new meaning in the medical field. Religious needs consist of basic needs arising from a specific religious context, such as those associated with diet, rituals and prohibited or customary medical treatments. Although spiritual needs can – but don't have to be – connected with religion, they can stem from a deep spirituality that is very individual and harder to verbalise, but that is as important as religious needs. Healthcare in countries with a higher proportion of medical specialists from other cultures (especially those with a colonial past), such as the UK and US, do not have a problem adhering to the various religious needs of patients, mainly because ignoring them may lead to a lawsuit and compensation claims. In Central and Eastern Europe, however, the situation is quite different.

This subject is very relevant today, given that the number of migrants is continuously growing in the Baltic and Slavic countries, and the discomfort caused by cultural differences between patients and staff can lead to lower-quality medical services and a longer recuperation process. We can't assume that the problem will disappear by itself and if ignored now, it could lead to more serious problems in the future. The pressure is on lecturers and professors at medical schools who are responsible for educating and preparing a new generation of healthcare professionals for a variety of sociocultural situations. In practice, however, lecturers not always are well prepared to face such a challenge, which may come from the conviction that the doctor makes all the decisions about life and health and "knows better" than the patient, whose obligation is to ignore any of their needs not directly connected with the current medical treatment.

Many relevant and interesting statistics and data can be found in materials collected and presented by participants at the annual conference "Medicine and Religion" organised by the Department of Human Sciences Faculty of Pharmacy of Wroclaw Medical University (Poland) by professor Bożena Płonka-Syroka and other researchers, which will be held for the fifth time this year. During the meetings of both practitioners and theoreticians at this event, many cases in which patients' religious needs are being ignored are analysed and discussed. The reasons for this ignorance and lack of understanding differ. Surprisingly, however, they tend to have nothing to do with xenophobic views, but rather with the level of pragmatic functioning of a given hospital or health centre. Some of the examples in this study are taken from a series of monographs of the same title created as a result of the sessions and discussions mentioned.

1. Examination of the place of religiosity and spirituality in the healthcare systems and acts of law in European countries

If we look closely at the documents that define health and sickness with regard to European countries, it turns out that they at least are not devoid of references to the spiritual sphere. In the case of older documents, we can see a strong connection with Christian traditions, even if not mentioned directly as in "human rights", an innate rights idea that has a strong Judaeo-Christian reference. Newer laws and acts, such as documents created by the World Health Organization (WHO), carefully avoid any references to specific religious traditions. They prefer to use the term "spirituality", which can be used without any religious connotations while still paying a large amount of attention to the spiritual perspective.

1.1. Health and the WHO

According to the WHO, "*health* is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [3]. If we look at a different approach of this definition, we see that one component has been added to the mix: "Health is a dynamic state of physical, mental, **spiritual** and social well-being and not merely the absence of disease or infirmity". Spirituality can be seeing as an important component of health[4]. The change was explained in the following way: "Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing process. The value of such spiritual elements in health and quality of life has led to a more holistic view of health that includes a non-material dimension"[5]. The spiritual aspect of health is understood as "a phenomenon that is not material in nature, but belongs to the realm of ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings, particularly ennobling ideas. Ennobling ideas have given rise to health ideals, which have led to a practical strategy for Health for All that aims at attaining a goal that has both a material and non-material component"[6]. It is evident that even in the mid-20th century, the understanding of health was based on the idea of a lack of disease, with changes only in the post-war world leading to the founding of the WHO and a revolution in the perception of health. This became more positive through references to general well-being and a more holistic approach. It wasn't until

3 http://www.who.int/about/mission/en/ (accessed 2018.01.06)

4 K. Chuengsatiansup, Spirituality and health: an initial proposal to incorporate spiritual health in health impact assessment, "Environmental Impact Assessment Review", Volume 23, Issue 1, January 2003, Pages 3-15, https://www.sciencedirect.com/science/article/abs/pii/S0195925502000379 (accessed: ???)

5 WHOQOL SRPB Group. WHOQOL and spirituality, religiousness and personal beliefs: report on WHO consultation. World Health Organization, 1998. WHO/MSA/MHP/98.2, 2–23. Geneva, Switzerland

6 World Health Organization Publication: Year 1991. Issue 9290211407. Chapter 4: The Spiritual Dimension

the end of the 20th century that, as a result of cultural and social changes, the spiritual element was added to the definition of general well-being.

In the case of the WHO, this was connected with a strong voice of representatives from Muslim and African countries, which we can find out more about from the account of Muhammad Haytham Al Khayat PhD, former deputy regional director of the WHO's Office for the Eastern Mediterranean[7]. The changes happened with the approval of so-called developed countries. For 20 years now, the spiritual aspect of well-being has also been an important element of what is defined as health in countries dominated by the paradigm of evidence-based medicine. The documents mentioned above are not, however, the only ones in which the religious aspect of general health should not be ignored.

1.2. European Convention on Human Rights

The convention itself does not mention something as detailed as religious beliefs in terms of healthcare. We should, however, take a closer look at Article 9, which talks about freedom of thought, conscience and religion:

"1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others."[8]

It seems that the concept of freedom of thought and religion, in connection with religious needs in a medical or pharmaceutical context and the relationship between the patient and the doctor or nurse, will not be considered an overinterpretation as long as it does not affect the freedom of others.

1.3. European and United Nations legal acts relating to freedom of religion

Among international legal acts, we can find many references to religious rights and practices that can be applied to healthcare. One of the most important is EU health policy, implemented through the Health Strategy, which focuses on equal chances for good health and quality healthcare for all, regardless of factors such as income, gender and ethnicity – which can be interpreted as "regardless of religious denomination" as well. Another important document is the European Convention on Human Rights

7 Khayat M. H., Spirituality in the Definition of Health: The World Health Organization's Point of View http://www.medizin-ethik.ch/publik/spirituality_definition_health.htm (accessed 05.01.2018)

8 European Convention on Human Rights: http://www.echr.coe.int/Documents/Convention_ENG.pdf (accessed 2018.01.06)

and Freedom (The Convention for the Protection of Human Rights and Fundamental Freedoms)[9] from 4 November 1950[10]. In The Universal Declaration of Human Rights from December 10th 1948 in 18 Article 9 states:

"1.. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching

3. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others".

Article 14 of the same convention forbids discrimination of any kind, including discrimination based on religious denomination.

Another document that should be mentioned is the Charter of Fundamental Rights of the European Union. Article 10 generally repeats the first part of the Human Rights declaration cited above. Article 22, however, adds that the Union shall respect cultural, religious and linguistic diversity[11], which can be applied easily to the healthcare context. Interestingly, we can't find any reference to the religious or spiritual aspects of health in a different, more-detailed legal act from 1997 called Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine[12].

The Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief[13] of 25 November 1981 can also be cited. This document highlights the need for freedom of religion and stipulates the prohibition of discrimination on religious grounds; it also refers to freedom to manifest religious beliefs and establishes the limits of said freedom. A crucial article is Article 6(h), which states that a citizen has the right to "observe days of rest and to celebrate holidays and ceremonies in accordance with the precepts of one's religion or belief". This can be understood as a statement that medical aspects should not limit the ceremonial sphere of a patient who declares his or her religious needs.

9 European Convention on Human Rights http://www.echr.coe.int/Documents/Convention_ENG.pdf (accessed 2018.01.06)

10 Ratified by Poland 15.12.1992 r.

11 Charter of Fundamental Rights of the European Union http://www.europarl.europa.eu/charter/pdf/text_en.pdf (accessed 2018.01.06)

12 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf98 (accessed 2018.01.06)

13 Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief http://www.un.org/documents/ga/res/36/a36r055.htm (accessed 2018.01.06)

1.4. Basic European laws and their interpretation

Drilling down to more relatable documents, we can look at individual constitutions of different countries where we are able to find references to healthcare. The Constitution of the Republic of Poland of 2 April 1997, for example, states in Article 25 Section 2 that: „Public authorities in the Republic of Poland shall be impartial in matters of personal conviction, whether religious or philosophical, or in relations to outlooks on life, and shall ensure their freedom of expression within public life"[14]. The specific set of laws and liberties concerning religious belief are specified in Article 53: "1. Everyone has the freedom of conscience and religion; 2. (…) the freedom of religion includes also (…) the right to use the religious help wherever they are; (…) 5. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others; 6. No one can be forced to participate or not participate in religious ceremonies"[15]. It becomes clear from the acts quoted that everyone has the right to religious help including in the area of medical care, and that the procedures or beliefs of medical staff cannot force a given person not to participate in religious ceremonies.

Professor Irena Lipowicz, former Polish Commissioner for Human Rights, has stated unequivocally that, according to the legal acts written down in the Constitution, "Patients staying in hospitals have the right to spiritual and pastoral care. In the event of the deterioration of health or life-threatening situations, the hospital is obliged to enable patients to contact a priest of his or her denomination"[16] – and all expenses should be placed on the institution where the patient is being treated.

It is worth highlighting that this opinion not only concerns people who belong to the religious majority in a given country (in Poland, this is regulated by additional rules established by a bilateral agreement between the Republic of Poland and the Vatican – the so-called Concordat), but also to patients belonging to any religion.

The documents cited above imply that the religious and spiritual sphere is not only a crucial element in the definition of health, but also a very important element of everyday life. It seems that on both the theoretical and abstract level of human rights, most – or even all – medical professionals are in agreement when it comes to being tolerant and sensitive to people of different religions and denominations. It is the practical level, however, that proves more problematic.

14 Republic of Poland Constitution http://www.sejm.gov.pl/prawo/konst/polski/1.htm (accessed 2018.01.06)

15 Republic of Poland Constitution http://www.sejm.gov.pl/prawo/konst/polski/2.htm (accessed 2018.01.06)

16 Deon.pl "Pacjenci mają prawo do opieki duszpasterskiej" ("Patients have the right to pastoral care") https://m.deon.pl/religia/kosciol-i-swiat/z-zycia-kosciola/art,18999,pacjenci-maja-prawo-do-opieki-duszpasterskiej.html (accessed 2018.01.06)

2. Everyday healthcare practices

At least three different reasons can be found for which patients' religious and spiritual needs can be faced with intolerance from medical staff. This mainly concerns places where there is little of no cultural diversity, especially former Eastern bloc countries, for which their economic status does not necessarily invite mass migration from culturally different countries. In such countries, the religious traditions of most citizens will often be considered obvious, whereas the analogical needs of minorities will not be a part of standard medical care. Furthermore, even in countries with a large number of immigrants from different cultures but a small number of medical personnel from the same countries, local specialists may ignore patients' needs linked to their religious beliefs.

The main reason for such ignorance – at least according to what medical specialists claim – is associated with financial issues. With financial support that is not enough to fund basic medical care services, additional services considered to go beyond standard procedures become an unnecessary burden for the system and have the lowest funding priority, particularly in comparison with biotechnological needs (although according to an OECD and European Commission report from 2017, "Health at a Glance: Europe 2016: State of Health in the EU Cycle", a bigger problem than the lack of money is the effectiveness with which it is spent and a general lack of funds for prophylactics[17]). The regulation of patients' rights does not determine the rules for funding in such cases. Bringing in a religious expert could therefore be a serious blow to the budget, particularly in small local institutions.

In addition, the time that medical staff can devote to a single patient is limited. According to a group of international researchers, the average amount of time intended for a patient in the doctor's surgery is 5 minutes (from 48 seconds in Bangladesh to 22.5 minutes in Sweden)[18]. Taking into account procedural measures, time needs to be added for writing prescriptions and filling in forms, leaving no time for the consideration of "additional" cultural, social, psychological or religious patient needs. The situation is similar in hospitals, calling into doubt the possibility of catering to all the spiritual and religious needs of patients.

Moreover, many medical professionals claim that they do not know how to behave or what to do with people who have "different, non-standard" requirements. Medical schools in Eastern bloc countries rarely include subjects connected with intercultural dialogue and diversity. Leading countries in this area are countries with a high number of medical staff from culturally different nations, such as the UK and US. In more monocultural countries, the process of change is visible but very slow. The increasing

17 European Commission and OECD report: Health at a Glance: Europe 2016: State of Health in the EU Cycle https://ec.europa.eu/health/sites/health/files/state/docs/health_glance_2016_rep_en.pdf (accessed 2018.01.06)

18 Irving G., Neves A. L., Dambha-Miller H., Oishi A., Tagashira H., Verho A., Holden J., International variations in primary care physician consultation time: a systematic review of 67 countries, *British Medical Journal* http://bmjopen.bmj.com/content/bmjopen/7/10/e017902.full.pdf (accessed 2018.01.06)

number of patients from foreign cultures can arouse curiosity and openness, but can at the same time provoke anxiety and concern connected with an inability to perform non-standard procedures (especially in terms of the higher costs and time needed).

Reasons can, however, go even deeper into the prevailing medical paradigm where the understanding of health and sickness does not allow for full acknowledgement of patients' spiritual and religious needs. Standard evidence-based medicine is deeply rooted in the 300-year-old biomedical model related to figures such as Descartes and Newton[19].

The biomedical model of health was built on positivist scientific cognition patterns based on the vision of reality of Descartes and Newton. This vision is mechanical, with the description of live organisms and human nature physical. The body is treated as a machine, and disease as a consequence of damage. The duality of human beings described by Descartes resulted in the influence of psychological, social and cultural phenomena on biological processes being ignored. Under this line of thinking, a doctor becomes a provider of health and the patient a passive receiver. According to Artur Ostrzyżek and Jerzy T. Marcinkowski, "if we stick to the therapeutic process accurately, the patient becomes a passive receiver of services and just another medical case. Medical specialists focus all their energy and knowledge on finding the causes of damage and disturbances in the organs and finding the right treatment. Meanwhile, a human being shouldn't be perceived only as a sum of their organs because each entity is much more than just a sum of its parts"[20]. This model has many limitations, with its main consequence being a total disregard for other, non-physical aspects of health. As mentioned before, the WHO acknowledged a different, more holistic approach to health in the 20th century. Medicine, however, is holding on to the biomedical model. Nevertheless, it should be noted that sticking to the rules of evidence-based medicine allows for an acknowledgement of the influence of psychological, social and cultural factors on health and sickness, and is most importantly a wall between evidence-based medicine on the one side and fake therapy on the other side that evidence-based medicine cannot cross if they do not adhere to the standards.

3. The influence of spirituality and religion on health

A starting point for this chapter is an article by Marcelo Saad and Roberta de Medeiros titled "Programs of religious/spiritual support in hospitals - five 'Whies' and five

19 The beginnings of the biomedical model reach as far as ancient philosophy, to a feud between the supporters of Plato and Aristotle. For Plato, a human was a soul trapped in the body, whereas for Aristotle a human was a combination of the spiritual and physical and the soul was superior but could not exist without the physical element. For Plato, the body was an obstacle for the soul that existed independently. Descartes based his vision of a human being on Plato, whereby to heal it is enough to know about body functions that can be observed and described, ignoring the soul completely; the body is a machine and its functioning can be explained by chemistry and physics. He consciously brought the phenomena of life down to pure mechanics and chemical reactions.

20 Ostrzyżek A., Marcinkowski J. T., Biomedical versus holistic model of health in theory and clinical practice, *Problemy Higieny i Epidemiologii* 2012, 93(4): p.684.

'Hows'"[21], in which they present factors relating to spiritual support in hospitals. Three of their assumptions have been mentioned earlier: one of these is connected with legal acts that can bind institutions to take the spiritual needs of patients into consideration, while patients who are aware of their rights can express their needs and expect institutions to accommodate them. Another factor is linked to the influence that patients' religious beliefs can have on their decisions on the treatments or medicines they are willing to take. Resulting conflicts that may arise between patients and doctors can negatively influence the effectiveness of treatment, or even cause legal actions and lawsuits for compensation.

The most important thing is that the vast majority of research shows that religious or spiritual well-being is related to better health. The positive influence of religion and spirituality on psychological well-being has long been discussed in science. Clifford Geertz, an anthropologist highlighted in the 1950s, highlighted that religion provides an explanation and offers solace during times of sorrow, pain and sickness, and when the only question a person might ask is "Why me?". In this line of thinking, religion can thus help people cope with traumatic situations, fatal diseases and serious health conditions in which medicine is unable to give all the answers. It is, however, possible that the influence of religion could conversely be detrimental and lead to serious ecclesiological neurosis, making treatment more difficult. Moreover, treatment can be hindered if there is a conviction that the illness is some kind of representation or punishment for sins or guilt, particularly if prayers were perceived not to have been heard and thus help with the condition.

According to research from the turn of the 21th century, there is a correlation between religion and improved health in a somatic sense (such as with regard to cardiological problems, slower progress of dementia and faster recuperation). Some voices have also flagged up that religion can have a positive influence on self-healing processes and bolstering the immune system.

However, according to Morten Magelssen and Olav Magnus S. Fredheim, "Even though a causal connection between active religiosity and good health has been established in the general population, there are no findings in prospective studies of patient groups that religiosity in itself increases survival".[22] Another important factor to consider is that fulfilling patients' religious needs can actually reduce medical costs. Recent research showed that patients in the final stage of cancer who experienced poor fulfilment of their spiritual needs required a higher level of care and spent more time in hospital, while the general cost of their hospitalisation was higher than for patients whose spiritual needs were catered for. Similar data can be found with regard to recuperation time among heart transplant patients. It can be inferred that, as Christina M. Puchalsk claims[23], spiritual commitment tends to enhance recovery from illness, and the more we

21 Saad M., de Medeiros R., Programs of religious/spiritual support in hospitals - five "Whies" and five "Hows", *Ethics and Humanities in Medicine* 2016, 11(5).

22 M. Magelssen, O.M.S. Fredheim, A spiritual dimension is important for many patients, Tiddskriftet. De norske legeforening, Issue: 2, 21 January 2011 (accessed: 2018.01.06).

23 Ch. M. Puchalski, Spirituality and End-of-Life Care: A Time for Listening and Caring, Journal of Pallative Medicine, vol. 5, nr 2, 2002, pp. 289-294.

neglect the spiritual sphere, the longer the process of convalescence becomes. Frustration and stress linked to cultural misunderstandings and ignorance surely do not contribute to the improvement of patients' health, particularly if this can lead to them asking to be discharged from hospital sooner than recommended. An example is a situation in which patients are given food that they cannot eat because of their religion, which may result in malnutrition and longer hospitalisation.

4. What can we do?

The most common casesrelating to religion reported by Polish medical personnel (namely by relating relating to kosher diets, Chinese birth rituals and the rejection of transfusions by Jehovah Witnesses) show that the problem does not lie in the attitude of personnel toward religious needs, but rather in the lack of established procedures. Each case is solved and treated individually, without any consultations with more experienced professionals. To resolve this, the first step would be to establish standard procedures that medical staff can follow. It is, of course, not possible to create a procedure for every situation, with the world of human values and beliefs too diverse to come up with one universal solution. However, a simple consultation with someone who has been in a similar situation can be invaluable. A long-term strategy could encompass the creation of some form of "manual" for the European Union based on the vast experience of some countries in this subject area. in that area. A procedure considered new in one country could be an established routine process in others. However, governments need to get involved and money is of course required, but as already mentioned, it should be achievable if it leads to future healthcare savings.

The proposed solution is closely related to the need to create specific relevant courses at medical schools (something that has already been followed in the US, where only three medical schools offered courses in spiritual topics in 1993, but by 2014 more than 75 per cent of medical schools offered patient spirituality topics in their curricula[24]). We have conducted classes on health in an intercultural context for many years (including for Erasmus+ students) and can say that most students are interested in this topic. Students pick these classes because they feel that these subjects will give them knowledge and skills they will need in the future. As far as those already employed in the medical profession are concerned, the best option would probably be an online course on the subject.

It could also prove highly beneficial to start a cooperation initiative with experts in the field of religion and spirituality, who could form a support group for medical professionals facing such issues for the first time. Such a group of consultants could also help patients who may not know which treatments are necessary to abide by – for example, suspending fasts for the period of hospitalisation by most Christian churches.

24 Bellwood L., Doctors and Diversity: Using Interfaith Literacy and Interfaith Dialogue to Improve Patient Care https://concordiacollege.edu/files/resources/1572-5177-1-pb.pdf (accessed 2018.01.06)

Conclusions

To summarise, we would like to repeat a quote by the WHO: "Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing processes".[25] Central and Eastern European countries have become monocultaral and monoreligious as a result of various political changes that took place after the World War II. More open borders and mass migration will also present a real challenge in the context of healthcare. It will always be important to highlight that tolerance and respect towards the religious and spiritual needs of patients is not only a case of "political correctness", but also an issue regulated by law and comes under a global definition of health, as well as being reflected in medical factors such as recovery and hospitalisation time. Furthermore, a patient whose spiritual needs are fulfilled will recuperate sooner and thus generate fewer expenses for the healthcare institution. Many options can be used to increase awareness, including a focus of attention on the education of healthcare personnel. Without more general systemic solutions, however, any help will only be short-term and not very effective.

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DVASINIŲ IR RELIGINIŲ POREIKIŲ REALIZAVIMAS ŠIUOLAIKINĖJE MODERNIOJE CENTRINĖS IR RYTŲ EUROPOS SVEIKATOS PRIEŽIŪROJE

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***Santrauka**. Sveikatos priežiūra ir ją atstovaujančios institucijos dažnai nepriskirtinos tai aplinkai, kurioje „švelniųjų" kultūros aspektai būtų reikšmingi. Klasikinė įrodymais grįsta Europinės medicinos paradigma linkusi interpretuoti žmogų biologinėje, bet ne dvasinėje plotmėje. Tačiau šiuolaikinėje Europoje (ir visame pasaulyje) besiformuojantys iššūkiai rodo, kad negalime neatsižvelgti į religinių skirtumų apraiškas visose viešosiose erdvėse. Rytų Europos šalys prarado savo monoreligijos dominantę, vis daugiau atvyksta pacientų, atstovaujančių skirtingas kultūras ir religines tradicijas. Vakarų Europos šalys, kurios susiduria su masiniais pabėgėlių srautais, taip pat privalo priderinti savo teikiamas sveikatos priežiūros paslaugas prie atvykstančių ir vietos (suteikus naują pilietybę) pacientų religinių imperatyvų. Tai suponuoja dideles problemas ir teisinei sistemai, kuriai vis labiau reikia struktūrinių ir sisteminių problemų sprendimų. Todėl ateities sveikatos priežiūros specialistų akademinis rengimas turėtų būti koreguojamas atsižvelgiant į šiuos veiksnius ir apimti daugiau tarpreliginio bendravimo kursų, atsižvelgiant ir į tai, kad Rytų Europos regione mažų mažiausiai trūksta tinkamų šios krypties vadovėlių.*

Reikšminiai žodžiai: viešosios erdvės, sveikatos priežiūros sistema, religija, tarpkultūrinis dialogas, tarpreliginis dialogas.

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