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# SPIRITUAL ASPECTS OF PAEDIATRIC PALLIATIVE CARE

In the last period of the life of an incurably ill person the most important things are the need to alleviate pain, presence of the family and near and dear ones and to provide the necessary spiritual and psychological support. Today the treatment of pain has become more effective than ever before, which does not mean that medicine is better able to separate illness from suffering. Neither does this make the presence of the family and near and dear ones less necessary for the terminally ill person, nor the support that should be given to him any less necessary. This means both spiritual and psychological support, but – although they complement each other – each one of them has its specific features and goals. Psychological support needs the proper medical training, including training that deepens and improves the awareness of the therapist. This requires qualifications on the highest academic level. Spiritual support, on the other hand, needs a mature personality, which does not always go hand in hand with knowledge and education. For such maturity is not achieved through training but as a result of the spiritual development of persons who rush to the aid of the suffering.

What applies to terminally ill adults, applies even more to children. They are more sensitive to pain, and they are less resistant to and less able to bear illness. They also need the presence of parents and family more than adults do. Thus the specific feature of paediatric palliative care consists in the fact that it encompasses not only the terminally ill child but also the child's near and dear ones and the medical personnel caring for the child. The painful spiritual and moral dilemmas that parents and family of sick children as well as doctors and nurses experience are well known. The latter often make use of volunteers, because it often happens – perhaps with the exception of hospices for terminally ill children – that the medical staff is incapable of working only in palliative care wards, because this is too nerve-racking. In such situations the professional help of a psychologist is not enough. Persons whose pre-

sence and attendance satisfy spiritual needs and deal with the dilemmas that cannot be resolved in any other way must support medical staff. Only in this way can life and departure in dignity be guaranteed to small patients and in so far as humanly possible can the attendant difficulties and dramas be reduced.

## The Integrity of Palliative Care

Since medicine has the rank of *philosophia secunda,* it is not exclusively a natural science but also a humanistic one. And since man is a religious being, it may be said that medicine to a certain extent is also a theological science. Illness, especially a terminal illness, destroys the entire person. Severe, intractable pain and progressive infirmity enslave the spirit, but destruction in the spiritual sphere subjugates and destroys the body. The medical personnel who apply their knowledge and experience to the patient ought to treat him as a person whose subject nature requires not only medical care but also profound human respect.

The history and philosophy of medicine point to very different philosophies of life on which help to the sick person was and is based. Despite this diversity, there is no doubt that the religious factor plays a crucial role in medicine. An intimate bond is formed between the doctor and the medical personnel on the one hand and the patient on the other. The more that joins them together, the stronger the bond is. It consists not only in co-operation in the diagnosis and treatment and recurrences of an illness and searching for means to combat it. It also means accompanying the sick person so as to minimise his painful isolation and separation from his surroundings and near and dear ones as well as to assist him in departing, when it happens and becomes unavoidable. One of the conditions for these actions to be really effective is preservation and consolidation of the system of values that shape the life of the sick person, including those connected with his religious faith. In this field the spiritual „affinity" of the patient and the medical personnel is of vital importance. Every person lives and develops in a certain context of a philosophy of life, spiritual and religious, which assumes respect on the part of others, and so the terminally ill person has every right that his identity, including religious, have full and favourable conditions for surviving the greatest test to which life subjects him.

An indispensable condition and sign of health is a person's internal harmony, which determines his spiritual and intellectual powers[1]. Human solidarity in its horizontal dimension, understood as building ties with other people, and in its vertical dimension, understood as building ties with God, is based on its recognition and development. This becomes a reality when the patient and the medical personnel understand each other well and co-operate with each other. This is made easier when they share the same or similar values, including those stemming from religious faith. Medicine perhaps never has played such a crucial role as today. This applies not only to progress in prevention, treatment and rehabilitation, but also in stressing the importance of accompanying the sick person through restoring and improving decent conditions of life and extending palliative care over the patient. This is all the more true of palliative care for children, which has developed in many countries in a manner that has no precedents in the history of medicine. Thanks to this doctors and nurses perform only „the last rites of hope".

Franz Buechner convincingly argued that certain forms of illness are a result of man's failure to have contact with the Absolute[2]. Thus the terminal state of a sick person may worsen, but his suffering resulting from the existential feeling of dread and loneliness may intensify if he has no support in his religious feeling or if he loses this support as the sickness gradually worsens. Thus the surroundings in which the sick person stays and receives care and from whom he receives care matter a great deal. Since everyday contact with suffering and the nearness of death causes severe dilemmas and spiritual problems, the medical personnel also need spiritual therapy that is consistent with their identity. The lack of contact with the Absolute may be just as painful and irreversible for doctors and nurses as it is for sick people. For doubts, perplexities and frustration are spread out over months and years of work with terminally ill persons, who evoke the feeling of impotence, disillusionment and hopelessness in doctors and nurses. The situation of an illness requires authenticity in the deepest sense from patients and healers alike, for a person's profound doubts and painful feeling of senselessness can be concealed only rarely and for a short time. The encounter of a terminally ill person with the medical personnel is an encounter of two

[1] H. Asperger, *Grundlagen der Willensfreiheit,* Arzt und Christ 2/1952, s. 19-21.
[2] F. Buechner, *Vom geistigen Standort der Medizin,* Freiburg im Br. 1957.

worlds that in many respects ought to be close and friendly to each other. Although in certain situations far-reaching „sympathy" of persons with different philosophies of life and religious convictions is possible, generally speaking these are exceptions that prove the rule that terminally ill persons ought to stay in an environment that understands and shares their philosophy and life attitudes.

The goal of paediatric palliative care is to transfer observations concerning all terminally ill persons to terminally ill children. For many reasons this is not easy. The personality of children is just maturing, which means that both their philosophy of life and their religious convictions are not sufficiently grounded and crystallised. The vast majority of these views grow out of the philosophy of life and religious convictions of their parents and immediate environment. They develop in the main not as a result of personal choice, but through imitation and family ties. When these ties are loose or, as sometimes happens, they do not exist at all, the terminally ill child desperately looks for examples to follow outside its immediate environment or is forced to rely only on itself, which intensifies its helplessness. Thus in such conditions the need for the integrity of paediatric palliative care becomes even more urgent. The child expects that the doctor and nurse will not only alleviate its pain and treat its illness, treatment that in the case of terminally ill children sooner or later becomes less and less effective. The child expects support and the development and sometimes even the transmission of a vision of life whose inseparable element is showing the sense of the mystery of suffering and death.

Thus presence at the side of a terminally ill child requires integration of the various help offered to it so that it would receive medical therapy together with satisfaction of needs that go beyond pathology of the organism. For this reason it is necessary to combine the efforts of the medical personnel with priestly ministration. The small patient will then gain the full dignity of a person, who in his difficult life situation receives help and solace. What is more, the integral dimension of palliative care ought to be not only the fruit of the skilful co-operation of the medical team, but also a manifestation of the personal maturity of everyone who is involved in care and help for the terminally ill. Doctors and nurses of hospices always ought to be aware that their work is both a mission and a calling. Many painful spiritual perplexities and dilemmas could be avoided if the medical personnel placed the troubles connected with their work in the context of the conviction that as such it is an expression of adhering to a genuine ideal and for this reason is not only necessary but also lofty.

## Three Dimensions of the Therapeutic Encounter with the Patient

The terminal illness of children gives rise to exceptionally painful moral and spiritual dilemmas. They stem both from internal confrontation with the situation of persons suffering for no fault of their own and from the general reflection on the meaning of human life, all the more dramatic in that it comes from the experience that it may be so suddenly and brutally cut short. The assistance that the medical personnel brings to sick children must be integrated with equally necessary help they themselves need in order to perform their attendance effectively. Hospitals and hospices are not only places of contacts of doctors and nurses with patients, but also places of genuine and personal contact, from which both sides never emerge the same as before. This aspect of the mission also ought to be clear from the very beginning. Someone who decides to help the sick, especially to help terminally ill children, ought to have a good presentiment of the dilemmas that they will have to face. Otherwise the position and fate of those children could find him completely unprepared, and this would manifest itself not only in the incapacity to take concrete medical steps but also in an even deeper and harder to overcome spiritual and personal immaturity. In contact with sick persons such maturity not so much arises as finds its expression.

According to Christian Scharfetter[3], the therapeutic encounter with the patient has three dimensions: intrapersonal, interpersonal and transpersonal. Each of them has its own profile and the various aspects of problems connected with paediatric palliative care stand out in its context. The order of the individual dimensions is not logical or chronological. They overlap and appear simultaneously. Even when only one of them is visible, the crisis being experienced by a suffering person is derivative of his general mental state. This applies especially to children, who react very emotionally and cannot be expected to distinguish the separate dimensions of human existence.

The first dimension of the therapeutic encounter with the patient is intrapersonal. It assumes intimate knowledge of the human body and its weaknesses as well as the conviction of historicity, that is of the transitoriness of human life. It must be emphasised that here we have to do with a characteristic asymmetry. The knowledge of doctors and nurses about the child's body and the causes of the illness that is destroying it is usu-

[3] Ch. Scharfetter, *Heilung und Wandlung*, Schweizerische Aerztezeitung 1987.

ally great and in a certain way non-transmittable. An adult takes account of the possibility of falling seriously ill and of the possibility that it cannot be treated. The medical personnel can count on his co-operation, which will be all the more effective when the sick person has long and thoroughly analysed life experience. On the other hand, the child has insufficient knowledge of the workings of its body and is incapable of rationalising the reasons for and symptoms of its illness. It is even more difficult for it to conceive of the transitoriness of its own life since it has not even yet reached maturity. Perceived in this dimension, the contact of the medical personnel with a sick child is difficult or considerably impeded.

However, it cannot be asserted that the child is incapable of acquiring awareness in these matters. Health is generally perceived as something normal, as an „original" condition that an illness disturbs, as a consequence of which a sick person is subjected to dangerous disintegration. It is very hard for adults to accept a situation of illness and the dangers it bears. They often deny it and rebel against it. In the case of a child, this is reversed to some extent. Tormented by a terminal illness, the child often does not know what health really is, for it only knows life in the context of its illness. This makes sick children not only more mature than their peers, but also more mature than adults, sometimes even than those who care for them. Although incapable of rationalising their difficult situation, they accept it as normal in a certain sense. The delusive ideology and advertisements, whose ideal is a young, healthy and handsome person, while everything else contradicts this ideal, do not yet infect children. The child is capable of deepening its awareness of the transitoriness of its own life on account of its simple (not necessarily superficial) religious faith. In turn, the child – often more easily than an adult – perceives death as a „passage", as a certain „gate" to a new life. The child does not ask questions about its radical distinctness, its otherness, because it has not had sufficient experience of the nature of its life or has not managed to become accustomed to it and to what it brings.

It is precisely on this plane that there is a wide field for co-operation of the medical personnel with a terminally ill child. One can say that its situation protects doctors and nurses from the cult of medicine and relying on their skills and capacities. In the encounter with a sick child doctors and the medical personnel must get used to and accept their own defeats. The world outside hospitals and hospices is full of triumphalism and swaggering reliance on oneself, all the louder the more it wants to

conceal various failures as well as the reality of suffering and death. On the other hand, the medical personnel know the price of health and life mainly from the angle of what threatens them and what can interrupt them. Despite the tremendous progress of medicine, its essence has not changed: It knows only what lives, but cannot explain what life as such is[4]. The situation and fate of terminally ill children teaches doctors and nurses humility, no matter what their philosophy of life and religious convictions are. This fact determines the inalterable relations that exist between medicine and religion. One may try to pass over them in silence or question them, but they irresistibly keep coming up, because every case of a terminally ill child renews the same and gives rise to new questions. The persons who care for a terminally ill child are not only providers of care, concern, consolation and support, but they are also receivers of what the sick child can enrich them with. From a sick child one can often learn the unshakeable hope that life has a deep and mysterious meaning that transcends the temporal order and that it places us on the threshold of death which we ought to cross with dignity. The small patient may be an enormous support for those who come to its aid.

Having this in mind, the medical personnel ought to be properly prepared for the spiritual encounter with a terminally ill child even before this happens. While receiving comprehensive knowledge of the child's body, the causes and progress of the illness destroying its vital forces, the prospects of the immediate and more distant future and the even more difficult challenges faced by the sick child and its near and dear ones, we should deepen our awareness of the historicity of human life, that is of its transitoriness. The fate of every person, as in a lens, is focused in the fate of a terminally ill child and greatly accelerated. In observing the progress of the illness and the intensification of symptoms heralding the nearness of death, doctors and nurses and employees of hospices then bring more complete and effective relief to the child, because they recognise something from the circumstances of their life and destiny in the child's position. We can say that when helping the child we also help ourselves in the deepest meaning of that word. The terminal illness of others, in particular of children, puts us face to face with the most fundamental questions about our own identity. Although one can push them aside and stifle them, this diminishes the value of our own life and

[4] M. Henry, *C'est moi la vérite,* Paris 1996.

in a certain way makes impossible or at least hinders comprehensive assistance to a sick child. If we stop asking ourselves difficult questions, we certainly will never decide to talk about them with the child and its near and dear ones.

The therapeutic encounter of the medical personnel with the patient also has an interpersonal dimension. This concerns interpersonal relations within the family of the sick child and outside the family. Contemporary treatment provided in specialised hospitals and medical clinics to a large extent condemns the patient to isolation and to a certain anonymity. Data on the state of health and progress of the illness are entered into a computer's memory and subjected to processing of various kinds, including statistical aspects. These data are supposed to help in determining the best ways of treating pain and prolonging life and also in determining the repeated causes of various anomalies in health. The sick person involuntarily is introduced into this hermetic world and then participates in it and helps to create it. Often this means a complete change in earlier life priorities, weakening or even breaking off ties with near and dear ones. From now on the most important confidant and authority for the sick person are doctors and nurses. Sensing that he does not know about everything that concerns him, the sick person often expects the „truth" from his near and dear ones, which often puts ties with family and friends to a severe test. Medical help conceived holistically ought to be linked with the presence and help of the sick person's family and friends.

It is similar but also different with a terminally ill child. It is similar because in the therapy of its illness the child also is subjected to hospital anonymity, which it fears more than an adult does. So the child needs visits and the presence of parents and near and dear ones, to whom it gradually adds the doctors and nurses caring for it. But the problem is that in bringing relief the medical personnel in the child's mind is associated with immediate suffering caused by operations and treatment. The permanent association of their frequency with relief of suffering does not come quickly or easily. One of the essential aspects of spiritual care for terminally ill children is to be cheerful in their presence and in no way to magnify the suffering that they can and must be spared. If the medical personnel treat their attendance in a routine manner, any impatience and intensitivity they show can have incalculable consequences that deepen the child's feeling of loneliness and isolation. Here the extremely useful importance and role of hospices for terminally ill children

should be emphasised. It would be very desirable if the conditions in which children suffer from their illness were as „normal" as possible. That can be achieved best in the bosom of the family and near and dear ones. If that is not possible, the medical personnel ought to try to be a substitute for the child's family in a certain way. This gives rise to difficult dilemmas, because it requires emotional engagement. That intensifies perplexities and difficulties when it becomes inexorably necessary to part company with the child. One of the most difficult spiritual challenges faced by the medical personnel comes up when they enter the circle of the family and near and dear ones of a terminally iII child. On the one hand, such closeness is supposed to protect against heartlessness, but on the other it is supposed to teach sensitivity that consists not only of emotions.

A lot depends on the family from which the child comes. Unfortunately, contemporary parents are ever less capable of taking a mature approach to the challenges posed by a terminal illness of their children. The ever louder appeal for all-around preparation of young people for life in marriage and the family unfortunately is not coupled with making them more sensitive to that side of human fate whose part are illnesses and the death of children outside from the usual order of things. Unable to cope with these challenges, young parents feel lost and helpless. They sometimes even shun their child, entrusting its care to others during the period of an incurable illness and the prospect of imminent death. In such cases the medical personnel and hospice volunteers ought to take up this difficult role and fill it. Hospices are invaluable in such cases. One gets the impression that the volunteers working in them are better prepared spiritually and more resistant to difficulties than doctors and the hospital personnel.

Since an illness is a disturbance of a certain order in man, it is not surprising that it introduces such a serious dissonance into interpersonal relations. All children need siblings and peers as the natural environment in which they can develop and grow up. But since terminally ill children are largely deprived of the possibility that the proximity of other children gives, one of the aspects of spiritual care over them is to help them to experience childhood and youth. While alleviating the suffering stemming from the material reality of the human body, other sufferings that come from isolation from the environment must not be ignored. Deeply concealed internal conflicts often accompany the feeling of isolation of a suffering child. These can give rise to new, serious psychoso-

matic illnesses. Neglect then leads to irreversible psychopathologic phenomena, which is not only a physical but also spiritual handicap. The latter brings serious mutilation, which threatens the terminally ill child even more than physical weaknesses and difficulties. The presence of peers, especially siblings, brings the child relief and performs very important therapeutic functions. This is possible especially in a hospice, where the child can stay in a family environment. When this becomes impossible in a certain stage of the illness, adults, namely the medical personnel, ought to take up part of this role. A careful and accurate medical diagnosis makes it possible to alleviate and mitigate physical ailments. But a correct and accurate spiritual diagnosis makes it possible to develop a kind of therapy that will bring the patient a sense of security and acceptance. This is especially important in paediatric therapy. There is no doubt of the importance of the role of the chaplain here, because therapeutic ministration is invaluable support for every palliative care.

There is also a third dimension of the therapeutic encounter of the patient with the medical personnel. Christian Scharfetter called this the transpersonal sphere, which encompasses the relation of the patient to nature, to the world and to God. A great threat to the proper perception of problems connected with this dimension is philosophical reductionism resulting from a narrowing or rejection of the spiritual and religious nature of man. This view perceives man as an immanent being in relation to the world and lacking any transcendental attributes. If the medical personnel treating a patient shares such a view, which fortunately is something rare, the patient is then forced to rely almost entirely on himself and does not get the spiritual and religious support that he needs so much. The opposite situation is also possible. The medical personnel might not suppress or conceal their religious convictions when treating a patient who prior to this did not profess any spiritual or religious values.

As in everything that concerns the previous dimensions, here as well the position of a terminally ill child reflects the dilemmas of every palliative care and at the same time has its own determinants and features. The child poses the same questions as the adult does; hence it must be treated seriously. The difference consists in the fact that the questions are expressed more spontaneously and more simply, which calls for properly applied spiritual therapy. Recently, also in the countries of the former communist bloc, questions are being asked more and more often about the relationships and correlations between medicine and religion, that is between treatment and healing on the one hand and salvation on the other. In this respect, a signifi-

cant transvaluation of values took place in the second half of the 20th century. Albert Camus in The Plague described a society torn between two poles, personified by doctors and priests, who proposed entirely different visions of healing and salvation. Today, on the other hand, doctors – irrespective of their philosophy of life and religious membership – do not treat their role and tasks in separation and isolation from others, but place it in the context of the work of psychologists and clergymen. This spurred the sudden development of medical ministration, which encompasses both terminally ill children and the medical personnel caring for them. The usefulness of this ministration cannot be exaggerated. It is becoming ever more obvious that where doctors and nurses end their attendance, the clergyman enters and develops a new thread of the therapy they have been conducting.

## Paediatric Palliative Treatment in the Christian Perspective

Since an important part of paediatric palliative care is the identification and inclusion of the religious dimension and destiny of man, there is no doubt that Christianity brings exceptionally valuable impulses into this field. They stem from the fundamental importance for human life of the belief in God and from recognition of the absolute uniqueness of God's interference in man's life through the person of Jesus of Nazareth. For many Christians His fate, the fate of God and man, especially torment, death and resurrection are the sole and most important support in difficult life situations, when they probe the meaning of transcendence. Regard for this plays an enormous role not only in the position of sick people but also in respect to persons from their closest and more distant circle who accompany them and in respect to those who come to aid their aid with professional medical assistance[5].

Christian thinkers have made a lot of effort to provide theological and religious justifications for suffering and death, especially of the suffering of the innocent. They explain that suffering is not and does not have to be a punishment for one's own sins or for the sins of one's near and dear ones, that it does not mean being removed from God and being marked by the stigma of being of less worth. They also point out the closeness of God, who through the mediation of doctors trying to bring relief in suffering comes to the aid of the patient. Ambroise Pare once spoke of this intimate co-opera-

[5] More in: Th. Leyener, *Konkrete Kontingenz – zur Theorie einer wachstumorientierten seelsorgischen Begleitung der Kontingenzerfahrung in Grenzsituationen,* Frankfurt a. Main 1988.

tion in these words: „I treat, but God heals." They also emphasise the specific Christian dimension of suffering, seeing an illness as a symbol of the transitoriness of our life, whose end is death and eternal salvation. These and similar explanations are put to the serious test of confrontation with the reality of the suffering of terminally ill children.

Since the sickness and suffering of children are perceived as an undeserved and unexplainable wrong inflicted upon them, we often have to do with rebellion against God in such cases. It is not a matter of denying His existence, for in certain situations this might even be the easiest way out. The problem is much more difficult and belongs to the field of theodicy: How can one reconcile the existence and presence in the world and in people's lives of a good and merciful God with debilitating suffering and especially with the suffering of the innocent?[6] These questions are constantly before the Christian or religious medical personnel in general. Pope John Paul II during visits in the Roman hospital „Bambino Gesu" took them up and elucidated them in a speech on 8 January, 1982. „A visit to a hospital, especially to a children's hospital, evokes from the depths of the heart certain fundamental questions on the meaning of life and man's existence: the constant existence of racking suffering, unavoidable suffering that afflicts especially the innocent, appears to the amazed and lost human mind as a real scandal. It can cause questioning and a dangerous crisis of those beliefs on which our intellectual, moral and religious life is based. The painful, heart-rendering cry of a child may seem to be a protest of entire humanity against the unfathomable silence of God, who permits the existence of such pain"[7]. The Pope expresses questions that are not always and not everywhere put in spoken words, for their very utterance is regarded as the manifestation of a rebellion that should never take place.

John Paul II reflects the perplexities and doubts of the medical personnel and the religious and moral dilemmas that patients feel, including small patients. Effective therapy and bringing relief to them cannot avoid or play down these problems. The most Important aspect of paediatric palliative care is to take up such difficult challenges courageously, both in the enco-

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[6] W. Chrostowski, *„Weź swego jedynego syna, którego miłujesz"* (Rdz 22,2). *Cierpienie dziecka jako próba wiary rodziców,* w: T. Dangel (red.). *Leczenie bólu i opieka paliatywna u dzieci. IV Kurs CMPK dla Lekarzy, 28 września – 8 października 1998,* Instytut Matki i Dziecka – Warszawskie Hospicjum dla Dzieci, Warszawa 1998, s. 118-125.

[7] Z.K. Szostkiewicz (opr.). *Ewangelia cierpienia w nauczaniu Papieża Jana Pawła II,* Warszawa 1995, s. 29.

unter with children and – which is sometimes much more difficult – in the encounter with their parents and near and dear ones. At the same time, John Paul II said: „Where the human mind seems to strike a wall of darkness and feel entitled to assume an attitude of rebellion, the Word of God takes us into the mystery of human suffering, presenting to our mind and experience Jesus Christ, the Son of God, as the embodiment of „the man of suffering" referred to by the prophet (Isaiah 53,3), Jesus deeply moved by the suffering of others and completely accepting the pain of his Passion as necessary stages on the way to the glory of the Resurrection"[8]. Looking from the Christian perspective, a suffering person is never alone. God is present in his life and fate as a witness of his struggle with suffering, and he never suffers alone but suffers together with Jesus Christ[9].

The skill and effectiveness of meeting the spiritual needs of patients stems largely from the fact that the medical personnel in the real sense of the word become witnesses to and participants of suffering. They are witnesses because the prolonged illness of patients and the arrival of ever-new ones to hospitals and hospices stores up ever new memories connected with terminally ill patients. The medical personnel rush to their aid and relief, but at the same time they observe patients' struggle with their hard fate. As regards terminally ill children and young people, those memories are especially painful and enduring. Every situation is unique, for the body of a child generally behaves more unpredictably than the body of an adult or old person. The medical personnel also to some extent become participants of this suffering. They also must preserve the necessary psychical and spiritual resistance, but one can never become entirely immune from the gradual destruction and waning of a child's organism and its approach to the end of its earthly life. Most cases leave permanent scars in the psyche of those who bring palliative help, even when doctors and nurses try to protect themselves against symptoms of „burn-out" and indifference. These things cannot be entirely avoided, but neither should they be exaggerated. In suffering one must perceive the opportunity for reflection on the fundamental problems of human existence, thus also an important impulse in the direction of personal conversion. John Paul II put it this way in the Apostolic Letter

[8] *Ibidem.*

[9] W. Chrostowski, *Opieka duchowa nad umierającym dzieckiem i jego rodziną*, w: T. Dangel (red.), *Leczenie bólu i opieka paliatywna u dzieci*, s. 109-117.

*Salvifici doloris* (February 11, 1984): „Suffering is supposed to serve conversion, which is a continuous process and helps the Christian to find his proper place in the ecclesiastical community"[10]. There is no question that the medical personnel have their own and unique place and calling in the Church community, which no one else can take up or replace.

In the process of assuaging pain and treatment the medical personnel very often feel their own impotence when they ascertain that in the actual position of the patient they can do no more. Then helplessness ought to turn into the deepest felt solidarity with the patient. Those situations reveal their real attitude and Christian maturity. John Paul II spoke of this in a speech to doctors: „Since for centuries the Church has regarded as Christian everything that is truly human, I believe that I ought to encourage you strongly to maintain ties of close, human solidarity with patients, solidarity that goes beyond the purely professional context. The patient in his heart of hearts also expects this of you. Besides, he stands before you with all the dignity of a human being, who – albeit in need, perhaps even bearing the signs of amputation – must not be treated as an inanimate object or even as an object of more or less clearly experienced operations. On the contrary, the person is always a subject and always ought to be treated as such. This is the fundamental dignity of man. And the attitude towards a suffering person – especially when this is a person stricken by cancer – is a test that certifies and shows what the true convictions are in this matter"[11].

An expression of this solidarity is to recognise in the patient a person whom society still needs. One of the most painful consequences in the destruction of the organism by an illness is the growing conviction that the patient is becoming a burden. He may even have such a conviction himself, which has a devastating effect on the human psyche and on his immediate environment, including even the medical personnel. Referring to these matters, John Paul II on September 11, 1983 addressed sick people in Vienna in the following words: „Sometimes – perhaps – you are seized by the fear that you will become a burden for us. Perhaps you were even told this or made to feel this. If so, I ask for your forgiveness. Of course, you need us, you need our help and care, our hands and our heart. But to the same degree we also need you. You must receive a lot

[10] *Ewangelia cierpienia w nauczaniu Papieża Jana Pawła II*, s. 103.

[11] From John Paul II speech delivered to the participants of Conference on Oncology, Rome, 25 II 1982; *ibidem*, s. 184.

from us. But you also endow us. Your sickness makes us aware how fragile human life is, how threatened and limited it is; it makes us aware that not everything that is planned can be realised, that not everything that has been started can be finished"[12]. It does not have to be argued that the fate of terminally ill children fully reflects and confirms these views.

John Paul II expressed himself in a similar spirit during his next apostolic pilgrimage to Austria on 26 June, 1988 when he addressed the sick in Salzburg: „You surely constantly meet people who pass you by indifferently and without noticing you, making you feel that you are superfluous, not needed. However, be assured that we need you! The entire society needs you. You stimulate your near and dear ones to reflection on the deeper values of human life, to solidarity; you put their capacity for love to the test. Especially for young people you are a challenge to develop what is best in them: solidarity and readiness to help those who in a special way are dependent on it"[13]. Terminally ill children more than anyone else release this kind of solidarity and put others to the test, „their capacity for love". When visiting the paediatric hospital in Olsztyn, Poland on June 6, 1991 John Paul II said: „We need children as guides to God, to the Kingdom of Heaven. And here is the beauty of so many children and in addition to that sick children, who are especially beautiful"[14].

The spiritual dilemmas of the medical personnel intensify especially in the face of the insurmountable suffering of terminally iII children coupled with calls for help and crying. In this field as well John Paul II shows us the way that Christian doctors and nurses should follow[15]. During the visit to the „Bambino Gesu" hospital in Rome he said: „In this Christian view the lament and tears of those who suffer, especially children, are not a severe protest but a pure, moving suppliant prayer, rising up from this earth to the throne of God, a prayer that all people would become purified and liberated from evil so that they could arrange their lives in accordance with the requirements of Divine revelation and become true children of God"[16].

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[12] *Ibidem*, s. 274.

[13] *Ibidem*, s. 280-281.

[14] *Ibidem*, s.281. [15] Zob. W. Chrostowski, *Rozwój duchowy pracowników hospicjum dla dzieci*, w: T. Dangel (red.), *Leczenie bólu i opieka paliatywna u dzieci*, s. 126-134.

[16] *Ewangelia cierpienia w nauczaniu Papieża Jana Pawła II*, s. 291.