7 oktober 2015: 11.15 – 13.00
Meeting with students Theology

The pastoral unit in University Hospitals Leuven

Welcome

11:15-11:25: Welcome
11:25-11:40: Film '*Cosmos of life*'
11:40-12:10: Presentation
12:10-12:30: Questions
12:30-12:45: Visit chapel
12:45-13:00: Prayer

1. Who are we and what are we doing?

a. *Who are we?*

The University Hospitals Leuven include four campuses: Gasthuisberg, Pellenberg, Sint-Pieter and Sint-Rafaël. The main activity takes place here at campus Gasthuisberg. This campus is by far the largest campus and most of our chaplains are working here. With 1995 beds campus Gasthuisberg is one of the largest hospitals in Belgium. More than 8800 co-workers work hard every day to guarantee differentiated an specialized care for our patients.

The pastoral unit is a 'small' unit within the University Hospitals Leuven. Our team consists of 11 Roman-Catholic chaplains: 7 women and 4 men (all between 24 and 65 years old). 10 chaplains are lay persons, Lucas is our only priest.

In the organization chart we have our place under the responsibility of the nursing director, together with the social workers. The team is responsible for its own activities since it is managed by the head of department – the 'head chaplain' (in accordance with 'head nurse'). Nine chaplains work in Gasthuisberg. At campus Pellenberg, which is the revalidation centre,

there is one chaplain. At campus Sint-Pieter – with its palliative unit – there is also one chaplain. At campus Sint-Rafaël there is no permanent chaplain, since the hospital is mainly an ambulatory hospital.

To this day all the chaplains of our team are Roman-Catholic. This situation is understandable due to the fact that University Hospitals Leuven are part of the Catholic University of Leuven. It is customary to try to keep up a good relationship with the diocese – in our case with the vicariate of Vlaams-Brabant. A pastor working in University Hospitals Leuven is recruited and gets paid by the hospital, but receives an appointment as chaplain by the bishop.

Since the majority (approximately 90%) of the Belgians do not understand themselves as catholic anymore – 'catholic' in a sense that they are actively involved in church life – one could argue that also an imam, a moral consultant, or a rabbi should be part of the team. This is, however, not the case.

b. What are we doing?

In the University Hospitals Leuven patients can contact a chaplain 24-hours a day, 7-days a week. We are present from 8:30 till 17:00 during weekdays. From 17:00 till the next morning there is always a chaplain on call. During the weekend there is also a chaplain on call. He or she is always in charge for Gasthuisberg, Pellenberg, Sint-Pieter and Sint-Rafaël. We are the only non-clinic caregivers in the University Hospitals Leuven who are on call during night-time. We mainly work in critical situations, in long-term counselling and in ambulatory care. Thus, the situations in which we end up are often very different and unpredictable (e.g.: the counselling of relatives who just lost a family member at the emergency department; or the counselling of an oncology-patient).

In this huge hospital were are depended on doctors, nurses and paramedic caregivers to inform us where we are needed the most. We do believe that not only the chaplain is responsible for giving spiritual care. To trace and give attention to spiritual needs is a multidisciplinary task for all the caregivers in the University Hospitals Leuven.

The hospital is divided in different care zones. For example the care zone of Oncology, the care zone of Cardiology, the care zone of Critical Units, the care zone for children etc. Every chaplain is in charge for one or two care zones. Since we are only with eleven chaplains in the University Hospitals Leuven we have to decide in which care zones we will be actively present. We just cannot be everywhere. Nevertheless, we try to integrate ourselves as much as possible into the different care zones, to be able to offer the best pastoral care.

In our team every chaplain concentrates on one or two particular care zones. Besides this zone the chaplain is also responsible for other care zones. However, he or she does not visit them as often as the particular care zone. This allows the chaplain to get specialized in the clinical picture of the patients which he or she is visiting and to get in touch with the specific spiritual needs of the patient. The advantage of specialization in one care zone is that you can

build up some knowledge and competence in that certain area and that you can become an integral part of the multidisciplinary care team of that care zone.

For example: the chaplain of the psychiatric care zone is encouraged to try to understand more about the different clinical pictures and to learn how to adapt his or her skills to the particular spiritual needs of psychiatric patients. The University Hospitals Leuven strongly encourages its staff to learn a lifetime. We can very easily attend workshops, trainings, buy books, … . As chaplain in charge for the pastoral team I follow leader shipment trainings etc.

During a regular working day we give guidance to people by means of pastoral conversations and rituals. Mostly the rituals are all sort of prayers: for example prayers for courage just before an operation, a prayer when somebody is about to die, the anointing or a blessing of the sick, baptism in critical situations. If parents are willing, it is also possible to have a farewell prayer/ritual for babies who passed away. We intend to help these parents so that the prayer or ritual always becomes a very individual expression towards their deceased child. Subsequently, these prayers or rituals are not necessarily catholic.

We work with the life story of the patient starting from the perspective of spirituality and philosophy of life. As head of the team I find it very important that the chaplains in my team always give recognition and appreciation to the various ways in which people try the express their own spirituality and inspiration. At the same time the chaplain can try to offer new and liberating insights to that particular life story, including elements from Christian perspective. I understand the task of a chaplain as being a signpost at the path of life of the patient. In my opinion hospital chaplains are not primarily send out to proclaim the Gospel at the patient's bedside. My own parish priest taught me when I was sixteen years old that before I ever start proclaiming the Word, people whom I encounter should be benefitting my choice for living in accordance to the life-giving Word. A chaplain is firstly called forward to give hands and feet to the Gospel.

Every Sunday we celebrate the Eucharist at campus GHB and PLB. Patients can attend the celebration in their wheelchair or in their bed. Volunteers bring them to the chapel and back to their rooms afterwards. During the week we have a prayer meeting at noon (12:45) in campus GHB. The prayer is open to staff, patients and visitors. Patients can also follow the celebrations on their bedside tv-screens (OctopUZ-screens).

The pastoral team is blessed with the help of many volunteers. Approximately 70 volunteers help to transport patients to the chapel and back for prayer, they bring the Holy Communion into the rooms and they bring flyers to the patients to inform them about the pastoral care services.

We also work closely together with the faculty of Theology and Religious Studies, for meetings like this, for research, and to offer places for students to do their practical.

2. Our perception of pastoral work in the University Hospitals Leuven

a. A holistic view on the human being, with respect for his or her dignity

The highly specialized care for patients in the University Hospitals Leuven is based on integral patient centered care coming from a holistic view on humanity. In the mission statement of the University Hospitals Leuven qualitative patient care is described as: "*In accordance with the external persons in charge care is personalized for every patient with his own medical, social and ideological context.*" In University Hospitals Leuven we intend to have attention to the human being as an entire person. All the important dimensions of the human condition have their own important place in the patient care.

There is the **physical dimension**: physical concerns focus on physical complaints, symptoms and needs of the sick person. But we are more than only our body.
There is also a **psychological and emotional dimension**. To advance welfare and health we also have to pay attention to the inner level of existence and feelings.
Furthermore every human being has an interconnection with other human beings. This is **the social and relational dimension**. If you are sick this has far-reaching consequences for your social life. Loneliness is one of the most heard spiritual needs in hospitals.
In addition every person also has **an existential dimension**. He or she is open to questions such as the meaning and significance of what he or she is going through. Pastoral care is a Christian colouring for the attention to his dimension.

These four aspects are symbolized in the massive work of art *het Teken* (the sign; Luc Peire) at the traffic circle, which you perhaps noticed when you came to Gasthuisberg. The giant column symbolizes the living upright human being in all its power and dynamism, but also the patient, vulnerable and weak.

b. Attention for the life story of every human being

The fundamental dignity of the human being in the different dimensions has a central place in the holistic view of humanity. In any situation he or she deserves to be treated with respect. The danger of reduction (fragmentation) has to be avoided as much as possible. The physical, psychological, emotional, social, relational and existential dimension are held together and merged into a 'chapter' of the life story of every person. Everything we live for, all our experiences, impressions and memories have their place in this story. Also the partner, family and others –each with their own story - have an important role in this. Human beings are entangled in greater and smaller stories. They determine who this human being is. These small stories shape a narrative identity.

Paying respect for the fundamental dignity and the narrative identity of the patient avoid that the ill person will be treated as an object, as a 'case'.

c. The Christian tradition of 'caritas', which is rooted in the believe of a caring and near God.

The specific characterization of pastoral care is the experience of and the believe in a personal God who accepts us unconditionally, a God who loves us and who wants to be near. God makes Himself known throughout human history as the one who says: '*I am He who is*'. This is 'the good News' of what we read in the great stories of the Old Testament, as well as in the Gospels and the Letters of the New Testament. In the life of Jesus Christ the vulnerable person takes a central place. He had a special attention to the poor, the sick, the oppressed. He proclaimed the hopeful and liberating message that God is unconditional love to them. Jesus' suffering, his crucifixion and resurrection confirms that God's love and proximity is stronger than death. For Christians this is the core message of their faith.

They experience this salutary and hopeful message also in their own life, in numerous occasions and encounters with other people. This experience is the ground and inspiration to go on realizing and creating palpable Gods name 'I shall be with you' in this world. That's why they want to share this "Salvation of God" with each other.

In the context of the hospital, where people are confronted with radical questions of life and border experiences, the pastoral service tries to incarnate God's love and proximity to all patients, regardless their beliefs and convictions, regardless the decisions they make in their life.

d. Questions of life and problems of life

A first indication for a substantive deepening of the concept 'pastoral care' is the gradually distinction between 'problems of life' and 'questions of life'.

In healthcare doctors and nursing teams are often focused on **problems of life** which are linked to the physical or psychological dimension of our human condition. This requires a way of thinking in which the disturbance is central and which requires an efficient solution. The professional caregiver analyses the problem, diagnoses and prescribes an appropriate treatment to cure the patient.

Questions of live are part of the existential dimension of human life. In the context of a hospitalization these questions are mostly related to the experience or the confrontation with the vulnerability of life. Such a radical and fundamental experience manifests itself in different ways: physical or psychological suffering, despair and impasse, imperfection, feelings of guilt, fallibility, disappointment and disillusionment, brokenness, internal contrast in life, … .

When people are confronted with these radical experiences, they often ask questions about the meaning and significance of life. The coherence of their life story is disturbed. 'Fractures' in life stories cannot be just strapped up. New perspectives are necessary. Liberating perspectives can help to 'cure' the existential ruptures in one's life story so that these ruptures are no longer paralyzing but give a deeper meaning to the human condition.

Terminological speaking we distinguish three ways of dealing with existential questions:

⇒ Philosophical way (coming from an immanent world view): life questions are answered without reference to a transcendent reality. Meaning and significance are not dependent on an 'external perspective'. The human being has to construct his or her own world view.

⇒ Spiritual way: in search for meaning a transcendent principle is not excluded, but it is not named.

⇒ Religious: in search for meaning and significance on the basis of a religious tradition (Judaism, Christianity, Islam,…) there is an explicit reference to a transcendent and personal principle (Yahweh, God, Allah,…) who is the source of the entire existence.

When we speak about pastoral care, we mean *Christian inspired existential care for people who are looking for useful answers on questions of life they are struggling with*. Therefore, it is important to notice that pastoral care is not exclusively addressed to people dealing with a specific Christian-religious reference framework.

3. Challenges for the future

The direction committee asks us to make a policy plan for the future. The plan is not concrete yet, but I would like to highlight the challenges we have for the future.

a. Broadening and widening

What does this mean? It sounds a little bit vague. The Belgian society has changed rapidly. The secularization still continues and a variety of different cultures and religions are present in this small country. In the past, we could say that all Flemish people were Roman-Catholics. Today it is not possible to make such statements anymore. More and more people do not believe any more. They do not feel themselves bonded with Christianity anymore. However, at the same time more and more people are searching for meaning in their life, searching for answers on all the big questions. They are posing questions about life and death, questions such as: 'Why are we here?; 'Is there someone or something that's bigger than us, someone we may call God?'. During my visits I meet a lot of patients who feel themselves religiously uprooted, but are still longing without belonging.

We are convinced that it is very important to be easily approachable for everybody, no matter whether the patient belongs to a certain religion or not. No matter whether the patient believes or not. Sometimes we even experience that people are more troubled when they don't belong to a certain religion. They need more guidance then those who find consolation in their faith. We will never force the other to believe, or impose our own faith on the patient.

It's all about an open way of listening. As pastoral team we try to facilitate different spiritual sources.
If we look at our pastoral care unit, we are all catholic chaplains. Nevertheles, we obtain good contacts with imams, rabbis, chaplains from different protestant churches, a moral consultant. But they are not hired by the hospital. It is on freelance base we call them.

There are some groups more present then others in the hospital. Few years ago the Jews asked for a Jewish kitchen to prepare their kosher food. The Muslims asked for a place to pray. Since there was no place available, we found a temporary solution. One corner of our chapel is now reserved for them to pray. It is surrounded by curtains, prayer carpets are there and a sign that shows the direction of Mecca. We would like to show you our chapel later.

In the future we would like to strengthen the dialogue with the different religious groups to see how we can offer the best spiritual and existential care to our patients, with respect for each religion and culture.

b. Managing our image

Our second challenge – and maybe the most difficult challenge – is to adjust the perception of the chaplain. I just described how the Belgian society has changed. The image of pastoral care that many people have is very old-fashioned. I even noticed it among my own friends. And I also see it sometimes in the reaction of patients. When I enter a room, they say: 'We were expecting an old priest, not a young man smiling all the time'. This shows us how people connect pastoral care to a church that's only for old people. And often people think that we have exactly the same opinions as the leaders of the Roman-Catholic church.

For example: the church strongly condemns euthanasia. As chaplains we do not want to take position in this difficult debate. We believe that every person has the right to receive pastoral care, despite the decisions made. We do not feel ourselves in the position to judge choices that people make. Unfortunately, sometimes people only reacts from presuppositions: 'You are working for the church so you will condemn my wish for euthanasia'. In such cases, we will explain that if they need us we will be there unconditionally. Being chaplain in the University Hospitals Leuven is sometimes being a 'cross-border worker'.

Often care givers only think of the pastoral team when a patient is dying on the nursing unit. Of course we also want to be there for patients in other crisis situations.

Thus, we spend a lot of time to get in touch with the different care zones to introduce people in our work. During the year we always visit the different care zones to give a presentation about what we have to offer, when and in which situations nurses or other caregivers can contact us.

c. Self care for the caregivers

The third challenge. We notice during our presence in the hospital that also our caregivers, the nurses, the physiotherapist, the ergo therapist, ... often feel the need to share their own life story and experiences at the hospital, the need to talk about their own sufferings. Especially when they are confronted with the death of a patient or with a situation that reminds them of a situation in their own family life. In an informal way we are already listening to them, but we want to see if we can do more for them in the future and maybe also in a more organized way.

d. Integration and specialization

I just told that the hospital is divided into several care zones, and that we as pastors are connected to this different zones. For our functioning it is important to integrate into the multidisciplinary teams to be part of the patient care. This means that we try as much as possible to participate in the multidisciplinary meetings. As being part of the multidisciplinary team we are expected to share information about the patient which is necessary for others to know, realizing that we all have the obligation to keep the information within that particular team. Sometimes, however, we experience difficulties with being part of the multidisciplinary team. Since, as chaplains we also have, like we call it, a 'free position'. This means that we can keep information to ourselves. Often patients share life stories which they don't want to be known by others. Thus, we always have to make the reflection of what is necessary for others to know to be able to give qualitative care. Mostly, if we share anything with the team we ask permission to the patient, for not damaging his or her trust. This is not always easy. Example.

It is important to us to integrate, but also to specialize. I already said something about it in the beginning. For example for the chaplains who are working on the psychiatric ward, it's good they know what kind of problems they can expect. What kind of spiritual needs often are existing within patients with psychiatric problems. The advantage of specialization in one zone means you can build up some knowledge and competence in that certain area.

e. A critical-ethical position

Each day, patients and caregivers in our hospital are confronted with ethical questions. Often these questions arise in situations at the beginning or at end of human life (medical abortion, euthanasia, how far to go with a certain treatment?). But we also think of the procedures to decide whether a patient may have access to specialized care or not, or whether a patient gets the chance to transplantation or not, or to determine the range of certain research and experiments?

As chaplains we have an important role to play. We can raise critical voices in these situations, to keep everyone critical: what is human, what are the limits? We see these questions are emerging because of the medicalization, of new discoveries and inventions and also because of the attitude of many people. We want to be in control, we like to have certainty.