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ANOINTING OF THE SICK IN THE INTENSIVE MEDICINE UNIT - LAST GREETING OR CALL FOR HELP

Abstract

The right of a conscious and competent patient to self-determination and the ability to make decisions about their own treatment affects the treatment outcome decisively. The patient's acceptance or rejection of the treatment options the doctor offers directs active medical interventions towards one of the goals: curing the disease or reducing suffering. In accordance with the provisions of the Health Care Act, every person has the right to practice religious rites during their stay in a hospital in the area provided for that purpose. During the COVID-19 pandemic, the functioning of the health system was changed. The need for isolation has led to a ban on visits and limited patients' communication with their families and loved ones, which was only possible using cell phones. Priests were allowed access, but with all infection prevention measures regarding medical staff. In that environment, the Anointing of the Sick remained the only active intervention that the ill person's family was able to do for their loved ones. For the family of the critically ill, the entry of a priest into a "forbidden space" is a spiritual act in which the priest can communicate with the sick in the role of an emissary of the family. He can also perform instrumental interventions by the act of anointing with blessed oil, with a desire for healing. The aim of this

text is to outline some of the aspects of isolating critically ill patients from their families and the role of the Anointing of the Sick in this situation.

Keywords: Intensive care units, COVID-19 pandemic, religious beliefs, prayer, Anointing of the Sick, family members, palliative care

Introduction

The intensive care unit (ICU) is a place of treatment for critically ill patients. The use of advanced therapies in the ICU is associated with risks the patient must be informed of and to which they must consent. The most important human freedom expressed during ICU treatment is respect for the patient's right to consent to or refuse the proposed treatment. The right of a conscious and competent patient to self-determination and the ability to make decisions about their own treatment are the most important determinants in patients' treatment in the ICUs. Accordingly, respect for the patient's personal, moral and religious needs is guaranteed by the Act on the Protection of Patients' Rights during Treatment in Intensive Care Units (Official Gazette, 2008). Respecting the patient's religious views is not the opposite of either the principles of the ICU treatment or the patient's desire to implement advanced intensive care measures (Colenda and Blazer, 2021; Khalid et al., 2021; Swinton et al., 2017). Elements of faith, such as knowledge, motivation, trust, and hope, can play a significant role during medical treatment and can significantly facilitate treatment decisions. Although some patients can expect the support of medical staff in meeting their religious needs, it is common for medical staff to provide emotional and professional support to the patient, while spiritual support is provided by family members and religious community members such as priests, pastors, and others (Kisorio and Langley, 2019).

Trust and hope are significant elements of psychological support for patients with severe mental illness or neurocognitive disorders, which are common in ICUs. Neurocognitive disorders such as depression, anxiety, and tiredness are more commonly observed in COVID-19 patients than in the general population (Hampshire et al., 2021) regardless of whether they were hospitalized or treated at home.

In ICUs, a number of invasive procedures, such as placing monitoring lines, intravenous lines or drains, make it difficult for the patient to move and communicate with the staff and loved ones. In that situation, visits by family

members provide insight into events related to the patient's current illness. Visits to the patients allow them to prepare for some of the future treatment outcomes: recovery and impending discharge of a patient with possible disease consequences or death because of health deterioration.

Patient participation in treatment decisions

The ability to make decisions about one's own treatment is one of the most important determinants of medical treatment, which is respected in all health systems. The patient's acceptance or rejection of the treatment options offered by the physician directs active medical interventions towards goals: curing the disease or reducing suffering. When patients are not able to decide on the continuation of treatment, mutual decisions about their treatment, together with them and the medical staff, are made by their relatives, usually family members - children, parents or sometimes legal representatives during a visit to the patient (Official Gazette, 2008).

In addition to participating in treatment decisions, visits from family members, relatives, and friends are important for maintaining a patient's mental health in the face of severe illness. Therefore, over the years, the introduction of different organization models has made changes aimed at greater openness of intensive care units to patients' family members with their significant participation in decision-making on treatment and care for patients (Ciufo et al., 2011).

The concept of patient- and family-centred care has been introduced in a number of hospital facilities to facilitate the technical conduct of visits (Ciufo et al., 2011). This organizational model usually defines the times in which visits can be made, as well as the content of the visit (Ciufo et al., 2011). During visits to the patient, family members can make a series of active interventions, such as informing the patient about events outside the hospital, participating in feeding and caring for the patient, or assisting with physical therapy. Patients feel the visits of family members as psychological support, have better motivation to cooperate with medical staff and have fewer feelings of rejection (Mistraletti et al., 2021). It has been confirmed that the incidence of delirium during ICU treatment is also lower in patients visited by their loved ones in the hospital.

Active participation gives family members a sense of meeting their own need to care for a sick family member and the opportunity to work with health care staff. In this cooperation, the family can see changes in the patient's general condition after medical interventions and, together with the patient, can

participate in making decisions about continuing treatment according to the medical staff's suggestions (Mistraletti et al., 2021).

As the deterioration of the health status of these patients is often unpredictably rapid, it is sometimes not possible to consult with the patient and their family about the possible outcomes of the envisaged treatment and obtain consent for them. These are situations when the patient's life would be endangered due to failure to take the procedure, or they would be in serious and imminent danger of severe damage to health. Due to diseases such as severe pneumonia caused by COVID-19 infection, patients often require immediate medical intervention, such as mechanical ventilation. During this time, the patient is dormant and unable to make decisions about their own treatment. In life-threatening situations and the need for these interventions, treatment decisions can then be made by the competent physician independently (Zakon o zastiti prava pacijenata, 2008).

Isolation in the intensive care unit

Isolation is a protection measure for particularly vulnerable patients, such as those with severe diseases and conditions of the impaired immune response. These are conditions after transplantation, burns, mechanically ventilated patients, et cetera and ICU treatment is often required in these patients. Isolation is also needed when the disease for which the patient is being treated may pose a threat to others, such as in patients with COVID-19 infection. Social contacts and conversations with friends or family members are kept to a minimum in isolation conditions to reduce the spread of infection.

Patients who have not been visited by their family members in ICUs are at higher risk of developing psychiatric disorders after discharge from the ICU and hospital (Moss et al., 2022). Moss and co-workers confirmed the significant effect of family involvement during patient visits on reducing the occurrence of post-stress psychiatric disorders one year after discharge from the ICU. The authors also suggest that those patients who do not have family visits should be recognized as at risk, and their family physicians should be aware of this (Moss et al., 2022).

Communication in isolation environment

Communication between family and patients, as well as family and medical staff, is extremely important for the critically ill. Through communication with the patient, the family has an insight into the development of the disease. By integrating a range of information about changes in health status and the patient's own impression of recovery, the family can create an image of the current treatment outcome. Talking to doctors about laboratory and other test results can confirm these observations. This communication will ensure that the patient and family are prepared to continue treatment at home, in the hospital, or for deterioration due to advanced disease and failure of applied treatment methods.

The use of cell phones, tablets and other communication gadgets sometimes remains the only connection between the patient and their relatives during the patient's isolation. Video link or telephone connection allows limited communication only with awake patients and is strongly encouraged during the COVID-19 pandemic (Vincent, 2022). It can be used to exchange information, but there is no opportunity of active family intervention towards the patient. Lack of quality communication between family members, a patient and the medical staff treating them is a source of stress and mistrust among family members (Feder et al., 2021). Decisions on the continuation of the treatment of a critically ill isolated patient are carried out by close family members, often by telephone.

For the family of severely ill patients and patients who have experienced extreme deterioration of health during hospital treatment, insight into health status changes is important from several aspects. The first is to participate in treatment through the provision of physical assistance to the sick such as assistance in exercising, getting up, or feeding. Psychological assistance to the patient is equally important, and ensuring two-way interaction strengthens both the patient and the family through understanding, support and encouragement to persevere in the fight against the disease. Mistraletti and co-workers believe opening COVID-19 intensive care units to family members is extremely beneficial. By staying with their loved ones in moments of their serious illness, they can more easily prepare for both good and bad treatment outcomes and accept them more easily (Mistraletti et al., 2021).

Performing religious rites during hospital treatment

Every person has the right to perform religious rites during their stay in a health institution in accordance with the provisions of the Health Care Act in the space provided for that purpose (Zakon o zastiti prava pacijenata, 2008). There are various regulations for dealing with isolation conditions and making decisions about treatment, consent to interventions, the scope of interventions and the performance of religious rites during the COVID-19 pandemic. Part of the EU and Middle Eastern countries, such as Croatia and Saudi Arabia, have opted to preserve patient safety and prevent the spread of infection. Visits to ICUs have been banned or only exceptionally allowed (Khalid et al., 2021). Family members and chaplains were minimally involved in the spiritual care and were not at the bedside at the time of the patient's passing.

Others opted for the concept of open ICU, the so-called family-centred ICU (Mistraletti et al., 2021). In this organizational model, the family and the patient are considered an indivisible whole, and even during intensive treatment, efforts are made to preserve the functioning and unity of the family. In addition to the possibility of direct communication, personal contact, and conversation, family members are enabled to have insight into the results of clinical examinations. They are allowed to participate in the patient's care and feeding, communicate with them and participate in joint decision-making on patient treatment (Colenda and Blazer, 2021). This possibility of communication and joint decision-making is considered especially important for elderly patients, patients with impaired cognitive status, or those who cannot make decisions independently due to other reasons. Such a reason is the use of drugs that affect the ability to make decisions.

Participation in religious rites such as prayer and participation during the care of the seriously ill patient is a significant confirmation of the family's steadiness. As changes were introduced in the functioning of the health care system during the isolation, they also affected religious rites in the conditions of the COVID-19 pandemic and isolation in ICUs. The changes are related to the avoidance of personal contact and the application of measures aimed at protecting the patient. Protective measures are obligatory during the performance of all rituals, including the sacrament of the Anointing of the Sick.

Religious and spiritual (R / S) values in most modern countries are the backbone on which advanced care planning for the patient is built. The integration of the patient's health needs, spirituality, neurocognitive abilities and religious understanding of life will result in a higher quality of treatment and

less stress for all participants in the treatment process. The patient's expression of desire for treatment and other activities during their stay in the ICU reflects their self-determination. Soliciting wishes about how to spend difficult days of illness can provide comfort in the face of severe illness, pain, uncertainty or possible death. The act of wishing makes patients' spiritual preferences more accessible. Wishes may be based on spiritual goals, such as communication with priests and achieving peace, comfort, and tributes. The patients may further prefer a spiritually enhanced environment and some symbols of their confession or specific religious or spiritual interventions (Swinton et al., 2017).

Anointing of the sick

In the New Testament (James, n.d.), there is a basis for the sacrament of the Anointing of the Sick. The original word used by the writer is the verb *astheneō* (ἀσθενέω), meaning weak.

"Is anyone among you sick? He should call for the elders of the church, and they are to pray over him, anointing him with oil in the name of the Lord. The prayer of faith will save the sick person, and the Lord will raise him up; if he has committed sins, he will be forgiven."

The act of Anointing the Sick is aimed at healing both body and soul. It has a therapeutic effect, primarily by psychologically strengthening the patient while coping with a severe illness. In order to achieve a therapeutic effect, patient cooperation through faith and prayers is required (Mateljan, 2021). Also, the significance of this sacrament is in the participation of others, the elders of the church and the community in helping the sick. If the patient is seriously ill, then this sacrament means forgiveness and preparation for death.

Through the Anointing of the Sick, one publicly expresses awareness of their own weakness and seeks help from God. Usually, due to illness, the patient is not the one who seeks the Anointing of the Sick, but on their behalf, family members, and the patient's loved ones, seek help. For the act of Anointing of the Sick to be complete and public, which is one of its determinants, the presence of the loved ones is assumed.

From the perspective of the patient, this act is mysterious because the Anointing of the Sick is shared by the person who is the mediator between the sick and God. The performer of healing is not the priest but God. Regardless, public participation as a witness to the act performed is necessary.

For the family of the critically ill and isolated patient, the entry of a priest into a "forbidden space" is a spiritual act in which the priest can communicate with the sick in the role of a family delegate. He can also perform instrumental interventions by the act of anointing with blessed oil, with a desire for healing. In this way, the family says goodbye to the sick person in a situation where there is no recovery.

In conditions of isolation, such as during the COVID-19 pandemic, this significant aspect of the publicity of the act of the Anointing of the Sick could not be accomplished because all but priests and the sick person were excluded from the rite. There is also no feedback for the family, who are initiators and seekers of the administration of this sacrament. Their call for help did not receive any feedback. It should include answers to questions such as: was the patient aware of what was happening, how he reacted, and whether something visibly changed in his condition after the sacrament was performed? Did the patient open their eyes? Was he/she more alert? Did his/her general condition improve?

How to avoid the separation of the sick from their family during the Anointing of the Sick

By protecting the patient from infections that could be spread from the outside, the visitors are at the same time protected from the disease that they could get from the patient. Therefore, the same behaviour in the ICU could be applied to the family and the priest. Some of them are summarized in Table 1.

Table 1. Protective measures that can reduce the negative effects of patient isolation enable family visits and religious rites according to their and the patient's wishes.

	Priest	Family
Execution of the sacrament	There is an initiative from the family.	There is an initiative from the family.
Isolation measures	A priest is not in isolation or quarantine.	A family member is not in isolation or quarantine.
Signs of disease	He has no signs of disease and no risk factors for the disease.	They have no signs of disease and no risk factors for the disease.

Existence of protective equipment	There is enough protective equipment.	There is enough protective equipment.
Staff assistance	There are trained individuals who will guide and teach the priest about his protection and movement through the "Forbidden Space".	Trained individuals who will guide and teach family members about their own protection and movement through the "Forbidden Space".

Applying these measures would reduce the harmful effects of isolation. This primarily means respect for the patient's right to self-determination and the family's participation in the spiritual care of the seriously ill.

Conclusion

The fulfilment of the patient's right to autonomy and self-determination in the intensive care unit is achieved through several aspects. Fundamental human rights in the intensive care unit include free visits by the family and the priest to the patient. Through them, the patient's legal right to religious services could be realized, including the Anointing of the Sick. Along with the implementation of protective measures, the Anointing of the Sick and other appropriate rites can be performed at the patient's bedside in the patient-and-family-centered intensive care. A study examining the attitudes of doctors, priests, patients, and family members could better answer the question of which segment of religious rites of critically ill patients can be improved and how these refinements can be implemented.

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BOLESNIČKO POMAZANJE U JEDINICI INTENZIVNE MEDICINE – POSLJEDNJI POZDRAV ILI POZIV U POMOĆ

Sažetak

Pravo svjesnog i kompetentnog pacijenta na samoodređenje i mogućnost donošenja odluka o vlastitom liječenju značajna je odrednica liječenja. Pacijentovo prihvaćanje ili odbijanje ponuđenih mogućnosti liječenja od strane liječnička usmjerava aktivne medicinske intervencije ka jednom od ciljeva: izlječenje bolesti ili smanjenje patnje. Svaka osoba u skladu s odredbama Zakona o zdravstvenoj zaštiti ima pravo obavljanje vjerskih obreda za vrijeme boravka u zdravstvenoj ustanovi u za to predviđenome prostoru. Tijekom pandemije COVID-19 dogodile su se brojne promjene u funkcioniranju zdravstvenog sustava. Potreba za izolacijom dovela je do zabrane posjeta i ograničene komunikacije pacijenata s obitelji i bližnjima koja je moguća uporabom mobitela. Pristup svećenika uz sve mjere zaštite od infekcije koje se odnose na osoblje medicinskih struka, bio je dozvoljen. Bolesničko pomazanje u tom je okruženju ostalo jedina intervencija i aktivni čin koji je obitelj oboljelog mogla napraviti za svojeg bližnjeg. Ulazak svećenika u „zabranjeni prostor" za obitelj teško bolesnog predstavlja spiritualni čin u kojem svećenik može komunicirati s bolesnikom, u ulozi poslanika obitelji. On također može obaviti instrumentalnu intervencije činom pomazanja blagoslovljenim uljem, sa željom ozdravljenja.

Cilj je ovog teksta iznijeti neke od aspekata izolacije kritično oboljelih pacijenata od obitelji i ulogu bolesničkog pomazanja u ovoj situaciji.

Ključne riječi: jedinica intenzivnog liječenja, COVID-19 pandemija, vjerski obredi, molitva, bolesničko pomazanje, članovi obitelji, palijativna skrb