Is there a difference between the Logotherapy of the dying and the usual therapy of the dying? In a Christian nation whose hospitals and educational institutions have in many instances been developed by Christians empowered by Christian thought and practice, why should such a consideration have to be set forth? Why should there be in the midst of the great successes of present day science surgically and chemotherapeutically the advent of the death and dying movement and the holistic medicine endeavor? It could very well be that we failed to read Alexis Carrel's "Man The Unknown." Now, fifty years since Carrel, we continue to know more and more about less and less of Homo sapiens. Somehow, we find ourselves unable to apply the mass of minute knowledge to the therapeuticism of the whole individual.

There have been the voices crying out in the wilderness of modern medical life. Those I have personally heard in addition to Carrel have been Paul Tournier, Griffith Evans and Viktor Frankl: two surgeons and two psychiatrists, Carrel a Roman Catholic, Frankl a Jew, Evans a Presbyterian and Tournier a Calvinist. To the list should be added one who is not a physician but who loudly speaks to us all concerning man and humanity: Alexander Solzhenitsyn. The voices may cry out, but who will listen? Our problem has been that we have had trouble listening at all—even to our patients or to ourselves. Nor do we listen to God, for we do not know His voice nor do we attempt to hear it.

To date, enlightened terminal care has been haphazard at best and eminently difficult for many patients and their families. Having just gone through this experience with a member of my own family, I can attest to the primitiveness of our Logotherapeutic approach to the dying patient and his family. We actually do a poor job of psychologically helping the patient and the spiritual aspect of care is virtually nonexistent. Those of us in the practice of surgery are quite caught up in the things of the moment. Many of our patients are referred and after the performance of the procedure, the patient to the referral physician. There are some surgeons who barely get to know the persons of those whom they submit to surgery. In our training institutions, the patient may never know who his surgeon is. (Recently in Philadelphia, two patients were operated upon erroneously because their surgeons did not know them.) If the patient should be inoperable or have a condition for which only palliation can be achieved, he is referred to an oncologist, or radiotherapist or to the appropriate physician who will hopefully interest himself in terminal care. We are adept at inserting the subclavian hyperalimentation vena-caths. We can insert the Swan-Gans catheter and obtain pulmonary wedge pressures. We can ascertain the blood gas values and the serum electrolytes. Our monitors show us the respiratory and cardiac functions. But in the midst of all of this, the family is deprived of the opportunity to deal with their dying loved one and the loved ones are not allowed to be said. The emphasis is totally upon the somatic aspects of dying and the Logo-psychologic consideration of the patient is neglected in most instances.

Cecily Saunders, Elizabeth Kubler-Ross and others have brought to world attention the fact that dying patients are not cared for in a consistently humane and thoughtful way. Their approach has been toward the psychologic aspects of dying with some consideration being given to the spirit of the patient. At a major conference on death and dying held in Montreal in 1976, again relatively little consideration was given to the spiritual aspects of dying. (Despite this area of deficiency, great strides have been made recently in the care of dying patients in some enlightened institutions.) We still have a long way to go in the psychosomatic care of dying patients; and one might say that virtually nothing is being done in the spiritual care of the dying patient, except by the clergy, and this is an extreme variable. In many institutions, nurses and paramedical personnel are forbidden to say anything to patients concerning their spiritual needs. This has been said to stem from the ideas of "separation of church and state." Thus, as death approaches and the somatic aspects of patient care are becoming increasingly unimportant while the psychospiritual factors are becoming more and more important, we find a startling neglect of patient care in these more vital areas.

What are the spiritual aspects of dying? How does one differentiate between psyche and Logos? Are these areas of the human being actually separable? Since the lower animals do not have spirituality the things of the spirit are distinctly human.
Frankl states in "The Doctor and The Soul," "The spiritual dimension cannot be ignored, for it is what makes us human." Dr. Frankl quotes Freud as saying, "Humanity has always known that it possesses a spirit; it was my task to show that it has instincts as well." Frankl then goes on to say, "But I myself feel that humanity has demonstrated ad nauseam in recent years that it has instincts, drives. Today it appears more important to remind man that he has a spirit, that it is a spiritual being." Thus there are two ways in which one can be spiritual, one can be spiritual in the sense of being spiritual, once conceived, must functionally be interrelated with the intellect; for with ether anesthesia (and its analogue alcohol anesthesia observed at some social gatherings), the lower and animalistic areas are set free as the higher intellectual centers are negated. This is also noted in some instances of prefrontal leukotomy and brain injury involving the frontal lobes. Morality and restraint are gradually abolished and spirituality ceases to be apparent.

Strangely enough to the natural man, however, increasing intellectual activity does not bring about increasing spirituality. Spirituality has to come about from a divine source. Although one has to will to be spiritual, it is just as difficult to will to increase spirituality as it is for one to increase his amount of gray matter. One cannot create spirituality as a result of ordinary or typical psychogenesis (natural mental development). Rather, one wills to receive the awakening of spirituality by asking God for His gift of faith in Him.

The peril of the intellect not restrained by the Spirit is that the greater the amount and quality of the gray matter, the greater the tendency becomes to make intellectual activity an end in itself and to begin to believe that intellect is spirit. Were this to be true, we should be seeing much spirituality in our society as we become more and more educated. But what do we see in our institutions--mental institutions, psychiatrists' offices full, and anti-gray matter substances, given license by natural man, creating ever increasing problems in our society, for example: alcohol, valium, librium, tranquilizers, marijuana, cocaine, heroin, demerol, sexual immorality, and psychic, mind-ablatting "meditative" methodologies.

My definition of psychospiritual health is that condition in which the thinking mechanism is secondary to Godly spirituality; in contrast to the usual state of man in which Godly spirituality is secondary to intellectual activity. It is the spiritual mind in contrast to the carnal mind. St. Paul equates the spiritual mind with life and the carnal mind with death (Romans 8:6). Jesus Christ tells us that one becomes spiritual by being born again--the second time being born spiritually in contrast to the first psychosomatic birth. Does this mean that the non-Christian or the Christian who is not born again is a-spiritual? No, he exists in a state of spiritual potentiality, having within him a spiritual nature which is held in subjugation by his intellect. This kind of patient requires spiritual care also--doubtless, to an even greater degree than one who believes that he has been born of the spirit. I sincerely believe that this is the patient described by Dr. Kubler-Ross who goes through the stages of dying which she describes as being: 1) denial and isolation, 2) anger, 3) bargaining, 4) depression, and 5) acceptance (On Death and Dying, MacMillan, 1969). Since my practice involves a large percentage of cancer surgery with young patients, I have observed that the attitude of my patients is largely one of trust and of peace. I have not observed the five stages in most of my patients. This could have to do with their spiritual status and with the fact that most of my patients are mine from beginning to end. The psychosomatic physician cannot give appropriate Logo-psychosomatic care. It might be said that the sick cannot give forth life and health; likewise, the incomplete cannot produce completeness (whole- ness). The physician (or nurse) who is totally oriented to the curative phase of patient care has difficulty when it becomes necessary to enter into the caring phase. Actually therapeutics should never be devoid of caring, but caring is a psychospiritual virtue and is not the ordinary product of the psychosomatic. In the psychosomatic patient who has only spiritual potential which has not been actuated (the natural man), there is a lack of understanding concerning the things of God. So he goes through profound psychological upheaval. He does not deny the diagnosis, become angry, belligerent, hurtful. He does bargain and search for all avenues of help. He does become depressed and may never accept his terminal status. He may destroy himself. (Again, this is the peril of the intellect not controlled by the Spirit.) This can all change if he makes his peace with God. Getting "saved" to me means becoming rescued from the violent destruction meted out by the individual upon himself.

The spiritual patient, when confronted with a diagnosis of terminal illness, also goes through a period of denial, (hopefully constructive denial). He often searches for divine healing through the offices of the church and we have seen miracles occur even in the most desperate of medically hopeless situations. If physical healing does not follow the healing of the spirit, the acceptance phase then comes to the fore and peace becomes the common attitude. Occasional patients who have been born of the spirit and in whom the spirit is primary do not want to be medicated with narcotics. Paul Tournier cites a doctor friend who writes of dying, "Not narcotics for me. I believe saying, "I will not have anyone medicate me from death forward." The patient is usually quite aware of the approach of death and spends much time in prayer and praising God. He is usually surrounded by loved ones and by those who truly care. It is a precious time and not a time to be feared or shunned by family or by medical personnel. In the final phases of dying, there may be a period of unconsciousness. This is not a time to cease praying and loving statements on the part of staff or family. Gradually the dying LPS patient appears to be more in heaven than on earth. (Continued next month with "Livng The Dying.") ***MSR***

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