

Existential Care and Religious Care in Holistic Palliative Care Based on Religious Pluralism, and Ethics for Recovery of Humanity in Medicine

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Abstract

Cicely Saunders' foundation of St. Christopher's Hospice in 1967 was an epoch-making start of palliative care. Saunders proposed care for total pains (physical, psychological, social and spiritual pains). Saunders' proposal was succeeded by WHO and was later defined as 'holistic care' by the International Association for Hospice and Palliative Care (IAHPC). However, there remain several challenging issues around spiritual care (existential care and religious care) in holistic palliative care. This review article aims to address three problems, i.e., a confusion between existential care and religious care, lack of religious pluralism, and dehumanization in medicine. First, Viktor E. Frankl's existential care (logotherapy) was presented from a universal standpoint. Then, religious care based on religious pluralism was proposed. Finally, ethics for recovery of humanity in medicine was discussed. For further elaborations, interprofessional and multidisciplinary discussions are required.

Keywords: palliative care, holistic care, spirituality, existential care, logotherapy, religious care.

ABBREVIATIONS

EOL=end-of-life, **IAHPC**=International Association for Hospice and Palliative Care, **PHC**=primary health care, **SCC**=supportive care in cancer, **UHC**=universal health coverage, **WHO**=World Health Organization.

INTRODUCTION

In 1967 Cicely Saunders founded the St. Christopher's Hospice in South East London [1]. This was an epoch-making step toward world-wide movement of palliative care. Concerning pain relief in palliative care, Saunders proposed care for total pains, i.e., physical, psychological, social and spiritual pains [2-5]. This care for total pains was succeeded by the World Health Organization (WHO) [6], and was later defined as 'holistic care' by the International Association for Hospice and Palliative Care (IAHPC) [7-9]. Certainly Saunders' original spiritual care was Christian religious care [2,3,10-14], but she later recognized the importance of Viktor E. Frankl's existential care [13] without any conceptual distinction between spiritual care and existential care. In this regard, Saunders' ambiguous concept of spiritual care caused a confusion around spirituality [15]. In cases, spiritual care means Christian religious care [16,17], and this has raised problems a

confusion between existential care and religious care and lack of religious pluralism. In turn, existential care that has been for a long time ignored in palliative care has been gradually acknowledged [7,18-24]. Both religious care and existential care are essentially required to accomplish holistic palliative care [7]. Frankl's logotherapy (existential care) has a more universal characteristics, and his original intention was establishment of ethics by recovery of humanity in medicine [25-29]. In addition, another WHO's contribution was integration of palliative care into community-based primary health care (PHC) [30-38]. WHO stresses that palliative care is an essential component of the comprehensive care in community-based PHC [23,24,31,35,36,39]. Accordingly, WHO refers to the ethical significance of palliative care in alleviating total pains of patients and families [31,36]. However, there remain several challenging issues around spiritual care (existential care and religious care) in holistic palliative care.

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This review article aims to address three problems, i.e., a confusion between existential care and religious care, lack of religious pluralism, and dehumanization in medicine. First, after summarizing development of palliative care and concepts around palliative care, we present Viktor E. Frankl's existential care from a universal standpoint. Then, we propose religious care based on religious pluralism. Finally, we discuss the ethics for recovery of humanity in medicine.

DEFINITIONS

Palliative Care

Modern palliative care was founded by Cicely Saunders. Her hospice model of palliative care is defined by 1. care for patients with cancer [1,5], 2. care at the terminal stage after termination of cancer treatments, i.e., end-of-life care (EOL care) [1,2], 3. interprofessional team approach [2], 4. bereavement care for patient's families [2], and 5. alleviation of total pains (physical, psychological, social and spiritual pains) [2-5] (Table 1). Indeed, Saunders' establishment of palliative care and hospice was an important step toward recovery of humanity in medicine.

WHO's definition of palliative care in 2002 ([6] p. 84) essentially succeeds Saunders' hospice palliative care model (Table 2), and WHO's palliative care model provides an improvement, i.e., early palliative care in conjunction with other therapies that are intended to prolong life such as chemotherapy or radiation therapy. This WHO's proposal was coincided with emergence of supportive care in cancer (SCC) [40-44].

Supportive Care in Cancer

SCC was prepared by oncology specialists and foundation of the Multinational Association of Supportive Care (MASCC)

in 1991 and publication of its journal *Supportive Care in Cancer* in 1993 were highly significant milestones [40,44]. The initial definition of SCC was "The comprehensive medical, nursing and psychosocial help that the patients need besides specific therapy of cancer" [45]. Its definition has been enlarged according to the recent development of SCC in the continuum of care from diagnosis through treatment to post-treatment care, as shown in Table 2. SCC is a specialized discipline of clinical oncology [41-43,46-49], and is called by several terminological varieties such as supportive care, early palliative care, timely palliative care, best supportive care, enhanced supportive care or supportive oncology [49].

Palliative care is different from SCC in three points. First, palliative care is provided for all the patients with acute illness, chronic illness (also known as noncommunicable diseases) and injury [8,31,33,35,50,51] while SCC is a specific supportive care for the patient with cancer as indicated by its definition [52]. Second, spiritual care that includes both existential care [7,8,23,24,53,54] and religious care [11,16,17] is an essential part of palliative care, but it is of secondary interest in SCC [55,56]. Third, bereavement care [2,6-8,57] is provided in palliative care, whereas it is out of scope in SCC [48,49].

Holistic care

IAHPC's consensus-based definition of palliative care in 2019 also adopts all the proposals of Saunders' hospice model and WHO's model: "Palliative care is the active holistic care of individuals across all ages with serious health-related suffering* due to severe illness** and especially of those near the end of life. It aims to improve the quality of life of patients, their families and their caregivers. * Suffering is health-related when it is associated with illness or injury of any kind. Health related

Table 1. Development and improvements of palliative care.

Contributors	Improvements	References
Cicely Saunders	Establishment of palliative care: 1. patients with cancer, 2. end-of-life care, 3. interprofessional team approach, 4. bereavement care for families, 5. total pains (physical, psychological, social and spiritual pains)	[1,2,14]
WHO Palliative care definition in 2002	Early palliative care in conjunction with other therapies that are intended to prolong life.	[6]
IAHPC manual of palliative care in 2013	Spirituality subsumes existential distress and religious issues. Spirituality and religion are not the same thing.	[7]
WHO Resolution WHA67.19 in 2014 and others	Extended application of palliative care to acute, chronic illness and injury.	[31,33,35,50,51]
WHO Resolution WHA69.24 in 2016 and others	Integration of palliative care into all levels of health care settings from primary through secondary to tertiary.	[32-34,36,37]

Table 2. *Definitions of the terms around palliative care.*

Terms	Definition	References
Palliative care	Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.	[6] p. 84
Supportive care in cancer	Supportive care in cancer is the prevention and management of the adverse effects of cancer and its treatment. This includes management of physical and psychological symptoms and side effects across the continuum of the cancer journey from diagnosis through treatment to post-treatment care. Supportive care aims to improve the quality of rehabilitation, secondary cancer prevention, survivorship, and end-of-life care.	[52]
Holistic care	Palliative care is the active holistic care of individuals ... Palliative care includes, prevention, early identification, comprehensive assessment and management of physical issues, including pain and other distressing symptoms, psychological distress, spiritual distress and social needs.	[8]
Comprehensive care	Comprehensive primary health care services, including health promotion, disease prevention, curative care and palliative care, that are integrated and coordinated according to needs, while ensuring effective referral system	[30]
Primary health care	Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, ... It is the first level of contact of individuals, the family and community with the national health system.	[34] p. 8
Continuous care	Cancer care continuum: 1. Risk assessment, 2. Primary prevention, 3. Detection, 4. Diagnosis, 5. Cancer or precursor treatment, 6. Survivorship, 7. End-of-life-care.	[59-61]

suffering is serious when it cannot be relieved without professional intervention and when it compromises physical, social, spiritual and/or emotional functioning.

** Severe illness is any acute or chronic illness and/or health condition that carries a high risk of mortality, negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress [8].” This IAHP’s palliative care definition proposes two improvements. On the one hand, it defines care for total pains (i.e., physical, psychological, social and spiritual pains) as ‘holistic care’ (Table 2). The term holistic care has been already proposed in The IAHP manual of palliative care ([7] p. 5). On the other hand, the IAHP’s palliative care definition emphasizes respect for cultural and religious issues: “[Palliative care] is delivered recognizing and respecting the cultural values and beliefs of the patient and the family [8].” This proposal may indicate importance of cultural and religious pluralism in palliative care settings.

Comprehensive care

IAHP’s palliative care definition [8] also refers to extended application of palliative care to acute, chronic illness and injury as proposed by WHO [31,33,35,50,51] (Table 1).

IAHP’s palliative care definition also indicates importance of the integration of palliative care into all health care settings (from primary through secondary to tertiary) that was proposed by WHO [32,33,34,36,37] (Table 1). In the Resolution WHA62.12 in 2009, WHO indicates integration of palliative care into comprehensive primary health care [30] (Table 2). WHO mentions to home-based palliative care service, community-based palliative care service and hospital-based palliative care service [33]. WHO also facilitates universal health coverage (UHC): “Ensured access for all people to needed promotive, preventive, resuscitative, curative, rehabilitative and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship ([37] p. ix).”

Primary Health Care

WHO has focused on primary health care (PHC) since the the Declaration of Alma-Ata in 1978 [58]: “Primary health care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.” WHO has successively strengthened PHC by integrating palliative care into PHC

in the Resolution WHA62.12 in 2009 [30], the Resolution WHA67.19 in 2014 [31], the Resolution WHA69.24 in 2016 [32] and the Declaration of Astana in 2018 [50]. In this context, WHO defines PHC as “Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community ([34] p. 8).” (Table 2) WHO also defines PHC as “A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (i) primary care and essential public health functions as the core of integrated health services; (ii) multisectoral policy and action; and (iii) empowered people and communities ([37] p. viii).”

Continuous Care

WHO recognizes the importance of care continuity: “Continuity of Care: the degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences ([34] p. 8).” In primary health care setting, continuous care is concretely defined as the processes of care across the cancer care continuum: 1. Risk assessment, 2. Primary prevention, 3. Detection, 4. Diagnosis, 5. Cancer or precursor treatment, 6. Survivorship, 7. End-of-life-care [59-62].

EXISTENTIAL CARE AT TERMINAL STAGE

Spiritual Care, Existential Care and Religious Care

Cicely Saunders found the spiritual pain as an essential one within the total pains [3,14], and her spiritual care was Christian religious care [2,3,10-14]. Saunders stated the Christian religious pain: “Spiritual pain: Not many people are likely to express the suffering of their doubts and griefs in religious terms. Nevertheless, feelings of failure, regret and meaninglessness which may be the deepest element in the ‘total pain’ are spiritual needs [3].” Saunders also told the Christian foundations of the early hospice: “Most of the early homes and hospices were Christian foundations, their members believing that if they continued faithfully with the work to which they felt called, help would reach their patients from the God who had himself died and risen again [12].” However, as Saunders herself acknowledges it [13], Viktor E. Frankl founded logotherapy (existential therapy) to address existential distress in 1946 [25] before Saunders’ finding of the spiritual pain. Many palliative care researchers [63-67] criticize that spiritual care is synonymously used as Christian religious care [16,17,68-72]. Indeed, this restriction of spirituality to Christian religious issues lack

religious universal (i.e., lack of religious pluralism) and raises practical embarrassment in East Asia, especially in Japan. In contrast, many researchers have promoted application of more universal existential therapies to palliative care to alleviate existential distress [18-24]. To clarify the ambiguous concept of spirituality, the IAHP manual of palliative care in 2013 proposes distinction between existential distress and religious issues, and indicates that spiritual distress can subsume under it both existential distress and religious pain: “Spiritual and Existential Distress: What is Spirituality? • every human being, religious or not, possesses spirituality; • spirituality encompasses the purpose and meaning of an individual’s existence; ... • for people with religious faith, spirituality is usually encompassed within their religion, but spirituality and religion are not the same thing ([7] p. 107).” This proposal dissipates the ambiguity around spirituality and improves the confusion between spirituality and religion, as also alluded by another study [73].

Existential Distress

Historically there are several schools of existential therapies including Frankl’s logotherapy [74]. Recently dignity therapy of Harvey Maxwell Chochinov [73,75-81] and meaning-centered psychotherapy of William S. Breitbart [54,82-86] have broaden the application of existential care to palliative care at terminal stage. Various symptoms of existential distress have been reported: anxiety, depression, loneliness and isolation; hopelessness; meaninglessness; and loss of autonomy and freedom [20-22,87]. However, the symptomatology alone is not sufficient to diagnose the existential distress [63,73,88].

Frankl grounded his logotherapy on three theoretical assumptions, 1. Freedom of will (Freiheit des Willens), 2. Will to meaning (Wille zum Sinn), and 3. Meaning in life (Sinn im Leben) [89,90] (Table 3). When the will to meaning cannot be realized in life practice (Lebenspraxis), then meaninglessness (Sinnlosigkeit) is caused [90] (Table 3). This feeling of meaninglessness (Sinnlosigkeitgefühl) is defined by existential frustration [25-29,91-95] or existential vacuum/emptiness [25-29,91-97]. This existential frustration induces secondary symptoms of existential distress such as anxiety, depression, aggression, addiction, despair and suicidality [27,90,92] (Table3).

Existential Care by Logotherapy

Meaninglessness that is commonly found in clinical settings of terminal palliative care is important for practices of existential care. Thus logotherapy and meaning-centered psychotherapy focus on patient’s finding of meaning at the

Table 3. *Logotherapy in terminal palliative care.*

Concepts	Theory and practice	References
Theoretical assumptions	1. Freedom of will (Freiheit des Willens), 2. Will to meaning (Wille zum Sinn), 3. Meaning in life (Sinn im Leben)	[89,90]
Cause of existential distress	The situation where the will to meaning cannot be realized.	[90]
Existential distress	Meaninglessness (Sinnlosigkeit), defined by existential frustration or existential vacuum/emptiness	[25-27,90]
Secondary symptoms	Depression, aggression, addiction, despair, suicidality	[90,92]
Role of therapists	Assistance to patients in their own search for meaning in life	[25,25,90]
Recommendations	Respect for patients' autonomy (Autonomie), freedom (Freiheit), responsibility (Verantwortung), conscience (Gewissen) and worldview (Weltanschauung)	[25,90,91,98]
Suggestions	Importance of patient's uniqueness (Einzigartigkeit) and concreteness (Konkretheit) in situations of patient's search for meaning in life	[25,29,99]

EOL stage. In this regard, we think that Frankl's logotherapy is a representative of existential therapy in terminal palliative care. First, many logotherapists have contributed to elaborating logotherapy [100-111]. Second, Frankl himself presented several cases of logotherapy for the patients at EOL stage: case 1 [25,91,92,94], case 2 [26,91], case 3 [92], and bereavement care of patients' family: case 1 [26], case 2 [27], case 3 [89], case 4 [92]. Third, among various schools of existential therapies, logotherapy is only systematically described by Frankl [25-27,29,91] and other logotherapists [100,102,103,105,107,109,111].

According to Frankl, the role of therapists at terminal stage is assistance to patients in their search for meaning in life (Table 3) [25,26,90]. Frankl recommends therapists to respect patients' autonomy (Autonomie) [25,90,111], freedom (Freiheit) [28,90,91,94], responsibility (Verantwortung) [29,89-91,93,98], conscience (Gewissen) [25,98] and worldview (Weltanschauung) [26,93,98] (Table 3). In addition, in accordance with other existential philosophers such as Martin Heidegger [112] and Gabriel Marcel [113-116], Frankl suggests the importance of patient's uniqueness (Einzigartigkeit) as an individual human being [25,29,89,97,99] and concreteness (Konkretheit) in situations of patient's search for their meaning in life [25,29,97,99] (Table 3).

Our clinical experiences [23,24,117,118,119] approve the good outcome by respecting patient's autonomy, freedom, responsibility and worldview. A female patient A with terminal cancer suffered from violation of her autonomy due to the enforcement of cytotoxic chemotherapy without her consent that was ordered by a previous oncologist. She was angry with this situation and fell into severe depression, feeling of isolation and suicidality. However, our intervention to stop this ethically unacceptable and

unnecessary cancer treatment at her terminal stage could recover her autonomy and rescue her from her abysmal existential distress. Then she could obtain her calm EOL time with her family and voluntarily accepted her death [118]. Another case of our holistic palliative care settings indicates the importance of our confirmation of patient's worldview in preparation of his dying time [119]. An aged male patient B with terminal renal failure did not choose hemodialysis. In a next step, his preparation of the terminal stage became an critical issue. In this regard, the communication of our respect for his worldview (Catholic faith) and our assistance in completing his sacraments (Eucharist, Confession and Anointing of the Sick) strengthened his faith. Then he could arrive at his tranquil last days full of piety.

Universal Characteristics of Logotherapy

It should not overlook the universal characteristics of logotherapy [25,92,93,98,99,120-125]. In fact, Frankl has repetitively warned and recommended four universal principles of logotherapy. First, Frankl stressed distinction between logotherapy and religion, because these are essentially different ([92] p. 143) (Table 4). Frankl frequently referred to this distinction [25,93,98,99]. Second, in order to apply logotherapy to both religious and unreligious patients, therapists should keep a neutral position on patients' worldview ([98] p. 60) (Table 4). Third, every medical doctor should distance himself/herself from his/her worldview ([98] p. 60) (Table 4). Fourth, even though logotherapy distinguish itself from religion, logotherapist can use patient's religious belief ([27] p. 122) (Table 4). These universal principles of logotherapy can be applied to the religious care at terminal palliative care from the standpoint of religious pluralism [125].

Table 4. *Universal characteristics of logotherapy.*

Principles	Description	References
1. Distinction between logotherapy and religion	Logotherapy does not cross the boundary between psychotherapy and religion. ... Psychotherapy aims at mental health. Religion aims at salvation.	[92] p. 143
2. Maintenance of a neutral position on patients' worldview	In principle, there are religious and irreligious patients. Thus logotherapy should rest in a neutral position for them.	[98] p. 60
3. Distance from therapists' own worldview	Logotherapist must apply his/her method and technique to every patient, believer or unbeliever, and every medical doctor should distance himself/herself from his/her worldview.	[98] p. 60
4. Utilization of patient's religious belief	When a patient stands on the firm ground of religious belief, there can be no objection to making use of the therapeutic effect of his religious convictions and thereby drawing upon his spiritual resources.	[27] p. 122

RELIGIOUS CARE IN PLURALISTIC SOCIETIES

Various views of life and death in different religions

There are numerous religions in the world. Since religious views of life and death are quite different among religions, mutual understanding between different religions and interreligious dialogue are substantially difficult. However, in concrete settings of religious care at terminal stage, it is desirable to provide religious care based on a certain universal model.

Historically speaking, Saunders' spiritual care was specifically Christian religious care and she repetitively expressed her Christian faith [2,3,10-14]. In addition, availability of several spiritual assessment tools such as SPIRIT [126], HOPE [127], FICA [128], FACT [129], MVASt [130] and BELIEF [131] is quite limited because these are specifically adjusted to the Christian religious traditions, and they may lack religious universal [23,132]. Thus, from the viewpoint of religious pluralism, Ian Markham criticizes the Christian bias in spirituality: "From the perspective of the world faiths, this debate about the role for spirituality in health care is very interesting. I have argued that much of the debate is operating with a secularized Christian understanding of spirituality. In other world faiths, there are alternative accounts of spirituality: in Islam, spirituality involves the extinction of the self; In Judaism, it involves the appreciation of the divine through the mundane; in Hinduism, it involves an awareness of the link between one's real self and the cosmic self; in Buddhism, spirituality is the cultivation of certain ethical disposition. Given that the account of spirituality used in health care discussions is quite different from the account of spirituality found in these four religious traditions, what exactly does this imply? [64]" In this regard, Mark Lazenby et al. [133] tried to summarize the views of life and death in the world's most

prevalent belief systems, including African Independent and Pentecostal Churches, Buddhism, Confucianism, Evangelical Christianity, Hinduism, Indigenous religions, Judaism, Mainline Protestant Christianity, Shi'a Islamism, Sunni Islamism, Roman Catholic Church, Sikhism, and Unitarian Universalist Christianity.

For instance, in Hinduism, acquisition of the speculation that the eternal principle of self (*ātman*) is identical with the eternal principle of universe (*brahman*) is essential in ascetic practice to attain deliverance (*mokṣa*) from reincarnation (*saṃsāra*) [134-139]. In Primitive Buddhism, a pessimistic view of life and death was dominant [140,141]. In the earliest Pāli documents *Suttanipāta* [140] and *Dhammapada* [142,143], Gotama Buddha's teachings can be retained [144]. In *Dhammapada* 277-279 [138,139,142], the Three Signs of Existence are defined as: 277. All created things are impermanent (*Sabbe saṅkhārā aniccā*). 278. All created things are sorrowful (*Sabbe saṅkhārā dukkhā*). 279. All the elements of being are non-self (*Sabbe dhammā anattā*). However, Buddhists' practice is simple. Attainment of *bodhi* (awakening or enlightenment) is pursued by practice of the Noble Octuple Path (*ariya aṭṭhāṅgika magga*): 1. right view (*sammā-diṭṭhi*), 2. right purpose (*sammā-saṅkappa*), 3. right speech (*sammā-vācā*), 4. right action (*sammā-kammanta*), 5. right livelihood (*sammā-ājīva*), 6. right effort (*sammā-vāyāma*), 7. right mindfulness (*sammā-sati*) and 8. right concentration (*sammā-samādhi*) [138,139,142,145]. As indicated by Markham [64], Buddhists require no divine being. They can attain their *bodhi* by their own autonomous ascetic practice before death. Borrowing Christian soteriological terms, autonomy and salvation before death (*salus ante mortem*) are the two characteristics of Primitive Buddhism. In Mahāyāna Buddhism, Dōgen who was the founder of Sōtōshū, a school of the Japanese Zen Buddhism, took over the two characteristic of the Primitive Buddhism,

i.e., autonomous practice of zen (a type of concentration *samādhi*), and sudden attainment of *bodhi* [139,146-149]. The latter can be understood as 'here and now salvation (*salus hic et nunc*, a variant of *salus ante mortem*)' if this is described by the Christian soteriological terms. In contrast, Shinran who founded Jōdoshinshū, a school of the Japanese Pure Land Buddhism, taught passive salvation by a divine being *Nyorai* (*tathāgata*) and salvation after death (*salus post mortem*) [139,149-151]. Thus these two schools of Mahāyāna Buddhism in Japan are substantially different and contradictory in practice and salvation. Zen Buddhism is characterized by autonomy and salvation before death (*salus ante mortem*), whereas Pure Land Buddhism is based on heteronomous salvation by *Nyorai* and salvation after death (*salus post mortem*). As a result, Japanese Buddhism contains marked internal religious diversity. Thus special consideration is required for Buddhist religious care in Japanese health care settings.

Religious Care in Religiously Tolerant Japan

According to Sadamichi Ashina [152,153], East Asia including Japan is the region where religious tolerance has been a spiritual heritage for religious and cultural pluralism. In Japan, especially in Kansai, the traditions of religious tolerance (magnanimity) [154,155] have contributed to the coexistence of different religions and various cultures [156-158]. This religious diversity in Japan may be convenient to promoting experimental trials of religious care in modern pluralistic societies where Christianity and other monotheistic religions are not dominant. The proper religion of Japan is polytheistic Shintoism [154,155], and Shintoism is essentially different from Christianity in its worldview, religious codes and even the concept of God [159]. In Japan, Christianity is an absolutely minor religion, but in general, Japanese people respect for Christianity [160]. In Japan, Christian religious care is provided in required cases. Our patient B presented above is an exemplified case in which Christian (Catholic) religious care provided by our multidisciplinary team brought about beneficial outcomes [119]. Buddhism is another imported religion. Buddhism has been

extinguished in India, while in Japan almost all the schools of Buddhism has been transmitted and conserved even today [161]. Therefore, Buddhist religious care is well studied and pursued and is provided by bonzes or specialist carers [162-164]. The view of life and death in Shintoism is optimistic that strongly contrasts with the pessimistic one in Buddhism [154]. Shintoism recommends simple daily worship of gods and goddesses [154]. This is an autonomous practice of ordinary Japanese people. In addition, there is no punishment of sin, and even after death everyone becomes a certain divine being [155]. The optimistic view of life and death in Shintoism affects our community-based palliative care settings in Western Japan [23,24,39,117-119,]. Many patients including the case A above mentioned want to autonomously decide their dying process, and preparation of dying before their death is important. This may mean that salvation before death is their interest. Fear of death is rarely found, and even as indicated by our patient, death is a transition into sleep in repose. In summary, religious care based on Shintoism can be characterized by autonomy and salvation before death (*salus ante mortem*). Furthermore, Shintoism influences Christians' thinking in Japan. Emi Hasegawa (Mase) points out that Ancient Shinto may be a significant element in the religious background of a Catholic writer Shūsaku Endō [165]. Endō proposes religious pluralism and universal religiousness [166].

Universal Religiousness

In modern pluralistic societies, mutual understanding between different religions becomes a critical problem. In this regard, it is worth considering the distinction between concrete religions and abstract religiousness that Viktor E. Frankl proposed [97]. The latter abstract religiousness is universally found in every religion, and this universal religiousness is variously defined by Frankl [97,98], Shūsaku Endō [166], John Hick [167-169] and Catholic Church [170]. By the abstraction of universal religiousness that consists of three steps (pursuit, participation and response), one can understand similarity between different religions, i.e. similar religious structure between

Table 5. Principles of religious care in modern pluralistic societies.

Principles	Significance	References
1. Recognize difference	Recognition and acknowledgment of difference between religions are an initial step.	[64,133]
2. Tolerate others	Tolerance for other religions is a <i>sine qua non</i> in multi-religious palliative care.	[8,53,154]
3. Understand similarity	Understanding of similar religious structures is obtained by abstraction of universal religiousness.	[97,98,139,166]

Christianity and Buddhism or between Zen Buddhism and Pure Land Buddhism [139,149]. For instance, Hick's ultimate divine Reality [167-169] is also found in similar ways, i.e., God of Christianity, *Dharma* of Zen Buddhism, and *Nyorai (tathāgata)* of Pure Land Buddhism [139]. This abstract universal religiousness may facilitate religious care based on religious pluralism in multi-religious palliative care settings.

Principles of Religious Care in Pluralistic Societies

In modern pluralistic societies where substantially different religious coexist, IAHP's recommendation "recognizing and respecting the cultural values and beliefs of the patient and the family" [8] is highly significant, and Daniel P. Sulmasy's proposal for five ethical principles for religious care (1. patient-centeredness, 2. holism, 3. discretion, 4. accompaniment and 5. tolerance) are essential ones [53]. However, a new approach accommodated to multi-religious situations is required. In accordance with previous three analyses on the interaction between different religions, we propose three principles of religious care that are adjusted to the situations in modern pluralistic societies, i.e., 1. recognize difference, 2. tolerate others and 3. understand similarity. First, recognition and acknowledgment of difference between religions are an initial step [64,133]. Second, tolerance for other religions is a *sine qua non* in multi-religious palliative care [8,53,154]. Third, understanding of similar religious structures is an essential requisite for multi-religious palliative care and is obtained by abstraction of universal religiousness [97,98,139,149,166]. The abstract universal religiousness is a key concept for mutual understanding and dialogue between different religions [139,149,171,172].

ETHICS FOR RECOVERY OF HUMANITY IN MEDICINE

Provide Palliative Care

The foundation of hospice and the establishment of modern palliative care were motivated by humane care for patients with terminal illness [1]. Thus it was an ethical challenge. In fact, WHO well recognizes it: "World Health Assembly Resolution 67.19 (in 2014) [31] states that universal access

to palliative care - the prevention and relief of suffering due to serious or life-threatening health problems or their treatment - is an ethical imperative [36]." and "It is the ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured ..., Palliative care is an ethical responsibility of health systems ...[31]." Indeed, it is an ethical imperative to provide holistic palliative care for patients and families who need it.

Overcome Dehumanization

Concerning dehumanization in medicine, Frankl indicates that medical doctors who focus only on manipulation of symptoms may overlook patient's humanity [25-29]. This leads to dehumanization [25]. Certainly Frankl does not use the term 'holistic,' but he intends to provide whole-person care for recovery of humanized medicine [25,92] based on his existential analysis of human person that is composed of three ontological dimensions, i.e., body-soul-mind (*Leib-Seele-Geist*, *sôma-psyché-noûs*) [26,28,29,91,93,94,98]. In particular, Frankl emphasizes the ethical significance of logotherapy (existential care) in whole-person care [25,27,29]. In other words, holistic care proposed by IAHP [8] is an ethical imperative, including care for existential distress [7,18-22].

Do Not Exclude Religious Care

Care for religious pain was an essential part of Saunders' care for total pain [2-5]. Thus special attention to religious care is emphasized in the framework of holistic care proposed by IAHP [7,8], and the importance of holistic care including spiritual care (i.e., religious care) has been repeatedly stressed by WHO [6,31,32,35,36]. Interprofessional team approach is adopted in hospice care [2,7]. However, it may fall into fragmentation of care. One of its drawbacks is abandonment of holistic care by leaving religious care out from the interprofessional team to chaplains. As indicated by Jane Dyson [63], C. Sims argues it and suggests: "Although nursing as a profession strives to care for the whole person, in reality the physical, social and psychological aspects are stressed whilst spiritual care is often ignored or left to chaplains or other spiritual leaders [173]." Accordingly,

Table 6. *Ethics in medicine for recovery of humanity.*

Recommendations	Intention	References
1. Provide palliative care	Universal access to palliative care is an ethical imperative.	[31,36]
2. Overcome dehumanization	Do not overlook patient's humanity, and provide holistic care including existential care.	[7,26,29]
3. Do not exclude religious care	Religious care is an essential part of holistic care to recover humanity in medicine.	[2,3,8]

in many Japanese hospice interprofessional team care settings, religious care is unfortunately excluded [174]. In contrast, our community-based comprehensive and holistic care setting provided by our multidisciplinary care team covers religious care as an essential humane care to recover humanity in the Japanese pluralistic multi-religious situations [23,24,39,117-119]. In sum, exclusion of religious care is a type of dehumanization and raises serious ethical problems in medicine.

CONCLUSION

Since Saunders' foundation of St. Christopher's Hospice in 1967, palliative care has well developed. However, there remain challenging issues around existential and religious cares in holistic palliative care. To improve these problems, existential care (logotherapy) from the universal standpoint, religious care based on religious pluralism, and ethics for recovery of humanity in medicine were presented and discussed. For further elaborations, interprofessional and multidisciplinary discussions are required.

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