

Chaplains as specialists in spiritual care for patients in Europe

Anne Vandenhoeck

Academic Centre for Practical Theology, Leuven, Belgium

KEY WORDS

professional chaplaincy, integrated spiritual care, European context, outcomes of chaplaincy, legal foundations

ABSTRACT

The development and the organization of chaplaincy in the European context are very diverse. The religious history and the culture of a country are the most determining factors. Still an increasing trend towards professionalism is noticeable. The number of professional associations for chaplains, for example, is growing. The need for professional chaplaincy is founded on the paradigm of whole person care and on the trend towards specialized care in hospitals. The whole person care approach implies integrated spiritual care because every person has spiritual needs and resources. Every caregiver should develop competencies to assess the spiritual dimension of a patient (primary care) and there should also be well trained caregivers who specialize in spiritual care (secondary care). In that perspective the chaplain is perceived as the specialist in assessing and dealing with the spiritual needs and resources of patients and families. The need for professional chaplaincy can also be seen as a right of a patient. In some European countries, like The Netherlands and Belgium, chaplaincy is mentioned in laws based on the right of freedom of religion.

Introduction Religion, spirituality, and health are strongly connected.^{1,2} Every patient benefits from spiritual well-being; most patients have spiritual needs or use religious coping; and the majority of patients use religious faith or belief to make treatment decisions or to deal with illness and death. Spiritual care is, therefore, an essential part of total care for patients³ but, all too often, it remains accidental care. Only when a patient expresses an explicit religious coping or an explicit religious need, caregivers will often recognize the need for spiritual care. However, in many cases, the spirituality of a patient remains unseen, undiagnosed, untreated, and not integrated into the whole care plan. Integrated, professional spiritual care requires spiritual competences of every staff member and chaplains who are well trained to assess and deal with a variety of spiritual needs, hopes, and resources of patients, families, and staff. In this article, we will concentrate on professional chaplaincy in the context of Europe. Who is a professional chaplain and what can he or she contribute to health care in a hospital? The organization and development of professional chaplaincy in Europe is still very diverse, depending largely on the religious history and culture of a country.

Nevertheless, we can see a growing trend towards professionalizing chaplaincy.

Professional chaplaincy in the European context: some examples One of the signs of professional chaplaincy is the integration of the chaplain in the team and the clear benefits that spiritual care and reflection on spiritual care have for the patients and the development of total care.

The head physician of the palliative care unit in the University Hospital of Leuven in Belgium integrated a chaplain in his team. On his request, the chaplain and a nurse of the team worked on a spiritual checklist to use in every patient's chart.⁴ Thus, the care for the spiritual needs of patients did not remain accidental but became integrated in the work of the interdisciplinary team. The checklist gave the team a language and means to discuss and care for the spiritual needs of all patients. The chaplain is expected to visit every new patient to explore his or her spirituality, is part of the weekly interdisciplinary team meeting, and mentors new staff members in recognizing spiritual needs of patients.

The Reade Hospital in Amsterdam, the Netherlands, specializes in rehabilitation and treatment

Correspondence to:
dr Anne Vandenhoeck, Academic
Centre for Practical Theology,
St Michielsstraat 4 postbus 3101,
3000 Leuven, Belgium,
phone: +32-16-323-895,
fax: +32-16-325-838, e-mail: anna.
vandenhoeck@theo.kuleuven.be
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of rheumatology. Two part-time chaplains offer spiritual care to 120 patients and 500 outpatients that are treated in the hospital. They are focused on giving individual support and on doing group work. Among others, they lead a group in the outpatient ward on spirituality and meaning of life, a meditation group for rehabilitation patients, and a bible group. All groups are focused on encouraging patients to use their spirituality, whatever spirituality may mean to each of them, in the process of rehabilitation and of being chronically ill. The head physician recognizes the importance of spirituality in the treatment process. He invited the chaplains to lecture about the spiritual needs of rehab patients to his assistant physicians. In cooperation with him, the chaplains started with funded research on the topic of dealing with powerlessness in paraplegia rehabilitation and on changes in meaning after brain damage or paraplegia.⁵

Training of chaplains in Europe There are different roads leading to being a professional chaplain. A typical well-trained Belgian Catholic chaplain in a hospital would have a master in Theology and Religious Studies at the Catholic University of Leuven. He or she would also have a second master in theology, specializing in chaplaincy. The extra master year includes a supervised internship of 3 months at a hospital, several courses which introduce the future chaplain into the medical world (introduction into diseases, introduction into mental health issues, etc.), and several courses which have to do with chaplaincy itself (ethics in health care, pastoral counseling, etc.). Once the chaplain starts working in a hospital, she or he has to continue being informed, trained, and supervised. But requirements for training and continuous education of chaplains do differ in the context of Europe.⁶

The European Network for Health Care Chaplains (ENHCC), which gathers representatives of professional associations and faiths, wrote in its Standards for healthcare chaplaincy: "Chaplaincy services are organized in different ways in different European countries. This is shaped by: religious faith group administration, health care institutions, state health care regulations and policies and chaplaincy associations. Chaplaincy services are delivered by clergy and lay persons who have been professionally trained ... They are authorized by their faith community and recognized by the health care system."⁷ Noteworthy indeed is the fact that most chaplains are recognized by their faith community as capable for the job and by the hospital who hires them after regular application procedures. The Standards of the ENHCC further refer to 4 requirements for continuous education for chaplains: 1) theological and pastoral education and reflection; 2) awareness of health issues; 3) clinical supervision; and 4) spiritual guidance.⁷ Institutional, regional, and religious differences in requirements for chaplains do not exclude the awareness in the major parts

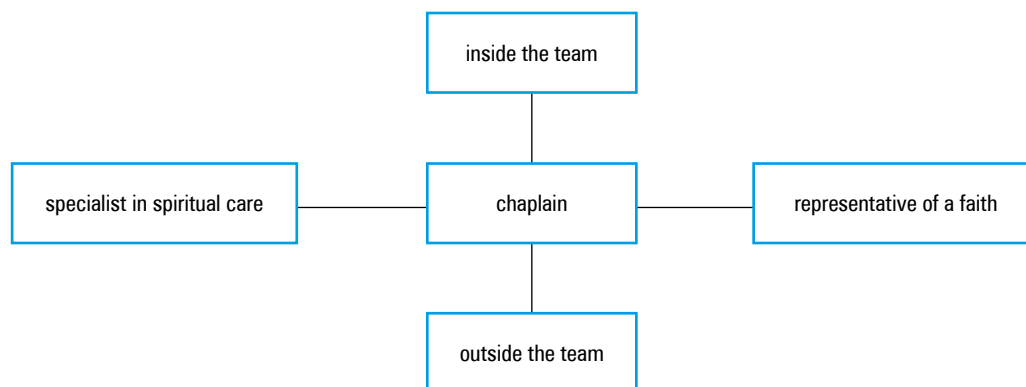
of Europe that chaplains need to be sufficiently trained and specifically prepared for providing spiritual care to patients in the evolving context of health care.

The quality of care and the professionalism of chaplains are not only guaranteed by their formation and training and their double recognition but also by their membership of an association for professional chaplains. The majority of European countries have professional associations for chaplains. These associations are either initiated by a faith community, a cooperation of faith communities, by a group of chaplains in a certain region or by a group of specialized chaplains. In the United Kingdom, for example, there is the Multi-Faith Group for Healthcare Chaplaincy, College of Health Care Chaplains, Scottish Association of Chaplains in Healthcare, and Association of Hospice & Palliative Care Chaplains.⁸⁻¹¹

The Scottish Association of Chaplains in Healthcare is a good example of what an association does for professionalizing chaplaincy. It is an association for professional chaplains from different religious backgrounds who work in Scottish healthcare. Its mission statement perfectly expresses what an association for chaplains aims to be: "to be a professional body representing the interests of chaplains in healthcare, to promote and maintain high standards of chaplaincy according to the 'Healthcare Chaplains Code of Conduct', to facilitate support and fellowship for chaplains, to promote training and educational opportunities for chaplains, to promote theological reflection and research in spiritual care, to establish and develop good working relationships with faith communities and other organizations concerned with the promotion of healthcare."¹² Several associations for chaplains do give a definition of who the chaplain is. The Dutch definition, for example, defines the chaplain as he or she who 1) gives professional counseling and care to patients in an institution; 2) based on his or her faith or belief; 3) based on a recognition by a faith community; 4) and who has a professional or academic master.¹³

A professional well-trained chaplain is not only able to give the required spiritual care to patients, family, and staff, but also to stand in the midst of several tensions (FIGURE). We give two examples. The first one is the tension, on different levels, between being a fully integrated member of the health care team and being an outsider. Chaplains usually have more than one ward to attend to and generally patient visits are not the only tasks of chaplains (there is also, for example, care for the caregivers, training of staff, ethics committee, etc.). In those circumstances, it is not possible to be a fully integrated member of each health care team. The challenge is to balance between being an insider and an outsider. In that respect, chaplains will also be mindful to balance between being a fully informed and informing team member and keeping the particular confidentiality linked to chaplaincy.¹⁴ The second tension is

FIGURE Chaplain in the midst of tensions



the one between being a representative of a faith or belief and being a specialist in spiritual care. Chaplains usually start with listening to spiritual needs, hopes, and resources of patients.¹⁵ They are specialists in dealing with the spiritual dimension of patients, whatever this dimension contains and however it expresses itself. At the same time, they need to be a representative of their faith tradition when people require this. Sometimes other caregivers can push chaplains towards one end of both tensions, thus solely seeing them as representatives of faiths and outsiders of the team (narrowing their contribution and professionalism) or the other way around (generalizing their contribution and perspective).

What do professional chaplains contribute? A national survey in the United States in 2009 showed that 90% of the participating physicians appreciated working together with chaplains.¹⁶ What do physicians think that chaplains contribute to care? An American research into what chaplains contribute to 13 large academic hospitals expresses the perspective of 30 pediatric physicians and 22 chaplains.¹⁷ Among the responders, especially pediatric oncologists work with chaplains and view them as part of the interdisciplinary team. A second recent American research describes the contribution of chaplains, their integration in the pediatric palliative teams of 28 institutions, and the perspectives of physicians on their contributions.¹⁸ Below is an overview of the perspectives of pediatric physicians and chaplains on what chaplains contribute to the care for patients as described in both studies (TABLE).

Pediatric physicians in both studies expressed that they saw chaplains as “spiritual care experts capable of providing support, education, improved patient-team communication and cultural competency.”¹⁸ Both researches showed that physicians and chaplains used other vocabulary to express the contributions of the chaplains. Therefore, chaplains need to be multilingual and able to translate what they do in the language of outcomes. Outcome-oriented chaplaincy provides a good start to learn an outcome-based language to express the contribution of the chaplain.¹⁵

Chaplains are dependent on the institution and the physicians for their integration and for the way they are allowed to work; therefore,

the understanding of what they do and the recognition of their expertise by other clinicians is fundamental. Some physicians work regularly with chaplains; others do not. Sometimes they do not know very well who the chaplain is, how to reach him or her, or what he or she does. The causes can be a lack of knowledge of the physician (when religion, spirituality, or chaplaincy was not part of their training) or shortage of the hospital (not hiring enough and well-trained chaplains and not demanding that chaplains should function in a health care team).¹⁹

The contribution of professional chaplains is described by physicians in terms of relieving spiritual suffering, addressing spiritual needs, performing rituals, relating in a context of support, communication, and counseling. The spiritual expertise of chaplains is based on their training in assessing the spiritual dimension of patients and in acting upon that assessment. They are capable of listening for any expression of the activity of the spiritual dimension in their conversations with patients and family members. The activity of the spiritual dimension is like breathing. People are usually not conscious of their breathing until they are out of breath. The same goes for the spiritual dimension. A person is always searching for meaning or experiencing meaning but the activity of the spiritual dimension becomes more apparent when a loss or lack of meaning is experienced. In that context, the patient may express spiritual needs. Chaplains are also trained to act upon those spiritual needs. They usually make a distinction between 3 levels in the spiritual dimension of a patient: a basic existential layer, a spiritual layer, and a religious layer. Professional chaplains are trained to work with a broad range of content in any of those layers. Recent theological reflection inspires chaplains to work in a narrative hermeneutical way. Where possible and appropriate, they try to connect the life story of the patient with a sacred story to contribute to meaning and hope. The last consultation meeting of the ENHCC expressed it in the following way: “In the awareness that human life is subject to many uncontrollable events, chaplains may give expression to incurable, irresolvable or tragic situations in life. They may help people to make a connection between their own life story and stories of sacredness or human wisdom

TABLE Perspectives of pediatric physicians and chaplains

Perspective of pediatric physicians	Perspective of chaplains
<ul style="list-style-type: none"> • chaplains are part of the interdisciplinary team • main task: support and counsel patients and families in coping with serious illness, especially in the context of crisis or end-of-life care; they also perform rituals • positive assessment of chaplains contributions • concern: how do they negotiate religious diversity? • describing contributions of chaplains in terms of 3 outcomes: <ul style="list-style-type: none"> – relieved spiritual suffering of patients and family – improved family-team communication – addressed spiritual needs of team 	<ul style="list-style-type: none"> • define broader contributions to patient care: we could be called in more situations • very few chaplains speak in tradition-specific language about their contribution; most of them use a general spiritual language • chaplains use broader frames and different vocabulary to express their contributions (process language): presence, wholeness, listening, empathy, healing

in relation to meaning and hope.”¹⁴ In the context of working with the whole person and being a specialist in working with the core of human beings, chaplains are focused on enabling the health care system to stay person-centered.

The care for the spiritual dimension during the admittance of a patient can never be the task of a specialist only. Primary care for all aspects of the person is a task for every member of the interdisciplinary team. Every professional caregiver should develop some essential spiritual competences in that regard. Van Leeuwen distinguishes 6 spiritual competences for nurses: knowing your own spirituality, being able to assess the spirituality of the patient, being able to communicate about the spiritual dimension of the patient, integrating the spiritual dimension in the whole person care, deliver primary care, and being able to discuss spiritual issues in the interdisciplinary team.²⁰ Owning spiritual competences is a necessary condition to work with the paradigm of integral care or whole person care. Often that paradigm is referred to without actually doing something about the spiritual dimension because it is the least easy dimension of the person to grasp. But the question is not “if the spiritual dimension is a relevant area in care but *how* and *to what degree* it manifests itself”.²¹ For example, many patients will make treatment decisions involving their current life view, their hopes for the future, or the meaning they want to experience. The search for meaning, the hope a person has and his or her life view are important parts of a spiritual dimension. Learning to see symptoms of the activity of the spiritual dimension can help caregivers to better grasp it.

Legal integration of chaplaincy in health care in Belgium and the Netherlands

In some European countries, such as the Netherlands and Belgium, the constitutional right of freedom of religion and belief forms the foundation for other laws where spiritual care for patients and clients is mentioned. The importance of spiritual care and of chaplains is expressed by those laws.

The Constitution of the Kingdom of the Netherlands states that everyone has the right to choose his or her religion or belief.²² Article 6 of the Constitution thus “concerns the freedom of

religion and belief. It states that everyone shall have the right to profess freely his religion or belief, either individually or in community with others, without prejudice to his responsibility under the law.”²³ The presence and employment of chaplains in health institutions such as hospitals and nursing homes is an indirect consequence of article 6 of the Constitution. In 1996, the Dutch Parliament approved a law on the quality of care in health care institutions.²⁴ Article 3 of that health care quality law is based on article 6 of the Constitution and states that if a patient or client needs to be admitted for more than 24 hours, the provider of care has to have chaplaincy available in the institution. The available spiritual care needs to connect as much as possible with the religion or belief of the patient or client. The Vereniging van Geestelijk Verzorgers in Zorginstellingen, the professional association for health care chaplains in the Netherlands, states that, in their country, it is generally accepted that the patient has a right to spiritual care, based on the Constitutional freedom of religion and belief.²⁵ If a patient wishes to use that right in a health care institution through spiritual care, the needed and wished for chaplaincy should be available. The benefit of such a law is that spiritual care for patients and clients in hospitals, nursing homes, and other institutions is grounded in the Constitution. The law is there to protect the right of people to live their faith or belief and spiritual care is seen as an essential mean to that right. The downside of the law is that it does not specify how spiritual care should be made available to patients or clients in the institution. In other words, an institution can interpret the law as an incentive to hire professional chaplains and have a spiritual care service or it can interpret the law as an incentive to call upon local clergy to come to provide spiritual care whenever needed. However, most health care institutions act according to the spirit of the law and hire professional chaplains who form a spiritual care service in the institution. The health care quality law of 1996 will probably be replaced by a new set of laws that is currently being prepared by the Dutch government and parliament. The new set of laws will be called “client rights” and, contrary to the health care quality law, will not define what health care

needs to offer but what clients have a right to. In all probability, the same formulation regarding spiritual care will be used.

The situation of the Netherlands is comparable to the situation in Belgium. Article 19 of the Belgian Constitution protects the freedom of worship and its public practice.²⁶ The Flemish parliament, Flanders is a member state of the federal state of Belgium, approved a decree on quality care in health care institutions in February 1997, which confirms the freedom of religion or belief stating that all institutions are obliged to offer care to patients and clients regardless of their age, sex, philosophical or religious conviction, and financial state.²⁷ Spiritual care in hospitals is arranged by the Royal Orders (federal governmental decrees) of October 1964 and January 1970. Both orders determine that representatives of religions and beliefs have the right to visit patients on their requests.²⁸ The ministerial letter of Minister De Saegher in 1973 explains the intention of the orders. Every patient has the right to spiritual care by a representative of a recognized religion (Catholic Church, Protestant churches, Orthodox churches, Judaism, and Islam) or belief (atheism, Buddhism). The individual freedom of the patient is a central issue in both orders. The patient determines whether he or she wants a visit from a representative of his or her religion or belief. If not, representatives need to respect the choice of the patient. Institutions are therefore obliged to respect the religious or philosophical beliefs of patients. As in the Netherlands, institutions are not obliged to hire their own chaplains, but almost all institutions do. Catholic hospitals will hire catholic chaplains, while pluralistic hospitals or state hospitals will generally hire catholic chaplains and atheist counselors. In both countries, all chaplains are paid by the health care institutions who hire them. In both countries, the existing associations for professional chaplains are continuously striving to improve the legal status of chaplains in health care.

Conclusion Health care institutions in most European countries hire professional chaplains as specialists in spiritual care for patients to be part of their interdisciplinary teams. In other parts of Europe, this still needs to happen. Not to do a favor to a church or faith, not for the power of chaplains but for the benefits of patients who do have heightened spiritual activity during their admittance and who deserve professional attention for their spiritual needs. There is still a lot of work to do in further training of chaplains, in communication of their contributions, and in training all clinicians to have a professional, integrated primary care for the spirituality of patients.

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Kapelani jako specjaliści od opieki duchowej nad pacjentami w Europie

Anne Vandenhoeck

Academic Centre for Practical Theology, Leuven, Belgium

SŁOWA KLUCZOWE

kontekst europejski, podstawy prawne, profesjonalna opieka duszpasterska, wpływ opieki duszpasterskiej, zintegrowana opieka duchowa

STRESZCZENIE

Stopień rozwoju i organizacja opieki duszpasterskiej w krajach europejskich są bardzo zróżnicowane i zależą przede wszystkim od tradycji religijnej i kulturowej danego kraju. Można jednak wyraźnie zaobserwować rosnącą profesjonalizację opieki duszpasterskiej. Zwiększa się na przykład liczba stowarzyszeń zawodowych dla kapelanów. Zapotrzebowanie na profesjonalną opiekę duszpasterską wynika z założeń modelu opieki całościowej oraz rozwoju specjalistycznej opieki szpitalnej. Podejście całościowe do opieki nad pacjentem zakłada uwzględnienie opieki duchowej, ponieważ każdy pacjent ma potrzeby duchowe i możliwości ich realizacji. Wszystkie osoby świadczące opiekę zdrowotną powinny mieć kompetencje w zakresie oceny potrzeb duchowych pacjenta (podstawowa opieka zdrowotna); ponadto odpowiednio przygotowane osoby specjalizujące się w opiece duchowej powinny pracować w ramach opieki specjalistycznej. W tym ujęciu kapelan jest postrzegany jako specjalista w zakresie oceny i realizacji potrzeb duchowych pacjentów i ich rodzin oraz rozpoznania ich własnych możliwości. Dostęp do profesjonalnej opieki duszpasterskiej może być także rozumiany jako prawo pacjenta. W niektórych krajach europejskich, takich jak Holandia czy Belgia, opieka duszpasterska jest uwzględniona w regulacjach prawnych wynikających z prawa do wolności wyznania.

Adres do korespondencji:
dr Anne Vandenhoeck, Academic
Centre for Practical Theology,
St Michielsstraat 4 postbus 3101,
3000 Leuven, Belgium,
tel.: +32-16-323-895,
fax: +32-16-325-838, e-mail: anna.
vandenhoeck@theo.kuleuven.be
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