Healthcare Chaplaincy as Specialised Spiritual Care

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The Christian Call for Healing in a Global Health Context

V&R

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Translated from German

VANDENHOECK & RUPRECHT

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Foreword

"God turns towards that
from which people turn away.
This is the motion that Christianity,
as a religion of healing, must endorse."[1]

Is healthcare chaplaincy[2] a health profession? This book argues that it is. Healthcare chaplaincy is one of many contemporary responses to the Christian call to healing. If the churches are indeed operating a "field hospital",[3] if they cannot surrender their specific task in healthcare to other stakeholders,[4] then chaplaincy as specialised spiritual care has its place in this overall mission. Whatever it means to carry out the Christian call to heal in a complex and highly specialized healthcare system, it is hard to deny that healthcare chaplaincy has a key role to play.

In this book, healthcare chaplaincy will be outlined in the light of current changes in interprofessional spiritual care and within the context of global healthcare. Even though chaplains work at the local level and care primarily for individuals, they contribute to global health. According to Peter J. Brown, global health, understood as a field of practice and study, is the largest social movement of the early 21st century.[5] What consequences does increasing global interdependence have for the further development of healthcare chaplaincy?

One thing is clear: On a global level, digital networking offers opportunities and incentives for the further development of healthcare chaplaincy. Chaplains engage internationally as never before in a common learning process in research, teaching and practice. However, there has so far been no concise, comparative overview of current developments in different countries. While there is a growing

1 Weissenrieder/Etzelmüller, Christentum und Medizin, 32.
2 In the following "chaplaincy" should be understood to mean "healthcare chaplaincy".
3 Guile, McManus, Healing Wounds in the Field Hospital of the Church.
4 World Council of Churches, Witnessing to Christ Today, 14.
5 Brown, Religion and Global Health.

number of empirical studies, there is rarely an attempt to synthesise the insights gained and to analyse them theologically.[6] This book aims to contribute to this learning process by gathering and analysing diverse strands of developments in the light of the Christian call to healing. The aim is to form a coherent picture of the current state of the art and stimulate reflection on the future of Christian chaplaincy in healthcare.

This book was written in the shadow of a global crisis. As the first pages were written, intensive care units in Milan and Bergamo were being overcrowded with those suffering and dying from COVID-19. Even their relatives were denied access to them. Hundreds of people died in isolation, without spiritual care, without receiving a final blessing. Their bodies were hastily packed into black plastic bags and taken to distant crematoria by military trucks. In many hospitals and nursing homes, there was a previously unimaginable systematic exclusion of relatives and, in some places, of chaplains as well. Simultaneously, however, strikingly different images went around the world: of praying care staff and chaplains wrapped in white and blue protective suits. New chaplaincy networks emerged, webinars on telechaplaincy were offered and countless leaflets on emergency spiritual care were distributed.

The coronavirus pandemic has accelerated the process of transformation in which healthcare chaplaincy has found itself since the turn of the millennium. What Jan Assmann once wrote about one of his own works is also true of the following pages: "[E]verything is in flux, and this book itself is in its own way part of that fluidity."[7]

This first version of this book was published in German in 2021. For the English edition, it has been thoroughly revised and expanded for a more international readership. I owe a great debt of gratitude to Dr. David Dolby for his careful translation and his critical feedback and to all those with whom I have had the pleasure of researching and discussing the field of healthcare chaplaincy and interpro-

6 Further perspectives on this topic can also be found in: Peng-Keller/Winiger/Neuhold, Christian Healthcare Chaplaincy; Peng-Keller et al., White-Paper.

7 Assmann, Cultural Memory, viii.

fessional spiritual care over the past years. Many thanks are also due to Prof. Dr. theol. Jörg Frey for his comments and suggestions concerning the first version of the third chapter. Finally, thanks are also due to all the chaplains whose experiences have enriched this volume. It would not have come into being without the manifold support and encouragement of my wife Ingeborg Peng-Keller, PhD – my heartfelt thanks!

Zurich, 31/10/2023

Introduction

"The Christian ministry of healing belongs primarily to the whole fellowship of the church, and only in that context to those who are specially trained for it."[8]

This book sets out an account of Christian healthcare chaplaincy as specialised spiritual care. Only in cooperation with healthcare professionals, who share responsibility for interprofessional spiritual care, can chaplaincy fulfil its mission in an increasingly complex healthcare system. Chaplains do not merely experience changes in healthcare first-hand; they can also help shape them more directly – *to the extent that* they are integrated in interprofessional teams and participate in processes of institutional change.

Situating healthcare chaplaincy within the Christian call to healing contributes to this task in two ways: *On the one hand,* this allows healthcare chaplaincy to be understood as a healthcare profession that contributes in its own way to therapeutic processes. Reducing suffering and supporting recovering and healing is not and never has been an exclusively medical task. It is, in any case, not a task that medicine can perform alone. It was and remains dependent on other professions – including that of chaplaincy. If chaplains see themselves as health professionals within the ambit of the Christian call to healing, they can articulate more clearly what they are able to contribute to health care without subordinating themselves to external goals.

On the other hand, by re-establishing its connection to the Christian call for healing, chaplaincy is put in a broader perspective. It contributes to the fulfilment of the church's broader commitment to humane, professional and just healthcare worldwide. Thus, no matter how hidden, fleeting and individual the work of chaplains may be – it is still part of a community effort. What distinguishes chaplaincy as specialised spiritual care from other ways of fulfilling the Christian call to healing is its particular professional profile. As

8 WCC, The Healing Church, 35.

a specialised profession in healthcare, it operates in clinical contexts which are characterised by a high degree of professionalism and a strong orientation towards scientific evidence.

This core idea will be developed and justified in three main steps. The first part of the book offers an analysis of current developments which are profoundly changing the field of healthcare chaplaincy. The second part turns to the Christian call to healing and explores its biblical and theological foundations. Finally, the third part explicates healthcare chaplaincy as specialised spiritual care and discusses related conceptual and practical issues. While the last part is written for those who are directly or indirectly responsible for healthcare chaplaincy, the first two parts are addressed to a broader audience: to all who wish to answer in their own way the Christian call to healing.

In order to make the architecture of this book tangible to the reader, each of its three parts opens with a view of the richly coloured, translucent agate windows in the Grossmünster in Zurich that the German artist Sigmar Polke completed in 2009, shortly before his death. This also builds a bridge to the place in which this book was written.

Like every book on existential questions, this one is also shaped by personal experience. A few remarks about how I came to write the book may be helpful for the reader. Much of the material for this book was inspired by the task of establishing a new professorship for Spiritual Care at the University of Zurich; no less important was my work as chaplain at the palliative care unit at the University Hospital Zurich. Beyond these immediate professional contexts, whose traces can easily be found on the following pages, are personal experiences that prompted me to engage more intensively with the therapeutic dimension of spirituality and the Christian commitment to global health.

Among them was my encounter with the Colombian theologian Carlos Alberto Calderón, whose blessing is still an encouragement to me and whose parting words remain with me to this day. In 1988, death threats had forced him to leave his hometown of Medellín, where a school now bears his name. Months later, I met him in a small flat on the outskirts of Zurich, where the Little Sisters of Jesus were renting accommodation. After a simple celebration of the

Eucharist, Carlos Alberto shared with us his experiences of struggle and escape. I was about 20 years old at the time, and I still clearly remember the joy he radiated, and his farewell on the platform of Zurich Main Station. He hugged me and said to me: "Do something good with your life!"

His desire to serve the poor and disenfranchised and to live among them led him to Kenya. In December 1995, he described his new field of work in a newsletter:

> "We are 550 km away From Nairobi, the capital of Kenya. […] Eighty-five kilometres away is Wamba, a small village in Samburu, where an Italian charity, in collaboration with the Diocese of Marsabit, built a large hospital more than 20 years ago […]. This hospital is a true miracle of solidarity, what some Latin American writers have called 'The Tenderness of the People'. Without this hospital, many would have died, and the Samburu population would have been decimated, because this is an area with a high risk of diseases such as malaria, polio, tuberculosis, cerebral malaria, etc., and the health care provided by the government is dreadful […]. It is to this very hospital in Wamba that we transfer the seriously ill in the mission van, which is pretty much the only vehicle in this area that drives. All priests, members of religious orders and lay people who work in the diocese of Marsabit have free access to this hospital. We're telling you this to reassure you, because if we have any health problems we can go to this hospital."[9]

A few months later, Carlos Alberto Calderón himself fell ill with malaria. A car breakdown prevented him from reaching the hospital in time. On Good Friday 1996, at the age of 46, he died. Shortly before he fell into a coma, he summarised in a farewell letter what inspired him in life and what he was prepared to die for. Today, when I reflect upon the Christian call to healing and the future of Christian healthcare chaplaincy, these words come to mind:

9 Homilía del domingo: "Nadie me quita la vida, sino que yo la doy por mi propia voluntad" (jesuitas.lat) (03/10/2022).

Barsaloi/Kenya, 28/02/1996

Full moon in the Samburu desert!
The ILAKIR DE ENKAI (the stars which are the eyes of God) have hidden themselves. Welcome Sister Death! The fever is increasing intensely; there is no way to get to the hospital in Wamba … As usual, our Toyota is broken down. I feel a great, joyful intensity in the face of death. I have lived passionately the love for mankind and for the project of Jesus … I die in overwhelming joy … I have made mistakes, I have caused people to suffer … I hope for their forgiveness!
How fitting to die like the poorest and most marginalised … Without the possibility of going to hospital … How good it will be when no one else has to die like this. I hope you will fight for it!

An intense embrace of love for all!

I Processes of Change and New Circumstances

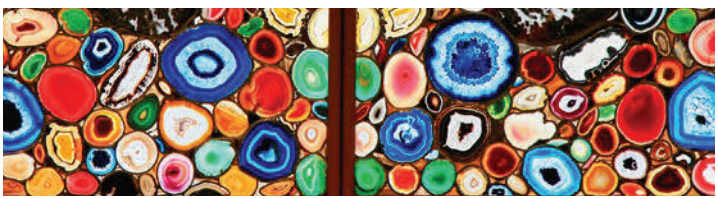

Fig.: Sigmar Polke, Agate window at the entry of the Grossmünster, Zürich (cutout) (© AdobeStock/juhanson)

As promised, this first part will open with a short meditation on Sigmar Polke's agate windows. These pieces of art reveal the work of formation processes over millions of years, hidden in rock cavities in the depths of the earth: colourful, banded, microcrystalline structures which, for all their geometric appearance, seem to belong more to the spectrum of biological forms: growth rings, ova, protozoa. What now seems like an animated cluster of microorganisms all nestled together was sourced from many countries around the world and carefully combined by the artist and his craftsmen. Processes of change that were historically and spatially far apart appear synchronised in the eye of the beholder. When viewed for a longer time, orders become visible: correlations of form and colour, encompassing configurations.

In their diversity and heterogeneity, the developments examined more closely in the following pages resemble these crystalline organisms. Only slowly do they fit into an overall picture. In this chapter, we shall consider and analyse transformation processes that do not merely relocate healthcare chaplaincy but may also profoundly change it. A precise analysis of the central factors is required if we are to take advantage of this change as an opportunity for growth. Three distinct processes of change need to be distinguished and analysed:

The first, which crystallises around the keyword "spiritual care", consists, to put it simply, in the expansion of the biopsychosocial health model to include a spiritual dimension. In this context, chaplaincy faces the challenge of clarifying its contribution to healthcare.

Setting the Conceptual Course: "Healthcare" instead of "Medicine"
Healthcare is understood in this book as the "totality of institutions and measures for health promotion and disease prevention, for the diagnosis and treatment of health disorders, diseases, and injuries as well as for subsequent rehabilitation".[10] Attending to healthcare in this broad sense means a significant expansion of the frame of reference for chaplaincy work.

10 Gutzwiller/Paccaud, Das Schweizerische Gesundheitswesen, 235 (translation by the author).

The second process of change concerns a development in western societies that can be put under the rough heading "post-secularity". For healthcare chaplaincy, the question arises as to how it can respond to the growing religious and ideological diversity and accommodate itself within a changed political framework, or perhaps even shape it.

The third process of transformation concerns the religious-spiritual field. In view of declining human and financial resources, the question arises how and to what degree the churches want to be involved in healthcare chaplaincy. At the same time, there are a number of remarkable spiritual movements in which spiritual healing practices play a decisive role.

Even if these three processes of change influence and sometimes reinforce each other, they must be kept apart analytically. Current developments in the field of interprofessional spiritual care, for example, are not necessarily linked to a secular context or religious diversity. For, even in a non-secular secular country such as Iran,[11] an interprofessional conception of spiritual care is increasingly being implemented.

Picking up the threads introduced at the beginning, I will first consider those developments in global health that are responsible for the greater attention given to the spiritual dimension in recent decades. In chapter two I will turn to the social and political circumstances that have changed markedly since the turn of the millennium.

11 E.g. Tigari et al, Meaning of Spiritual Care.

1 Spiritual Care: The Reintegration of the Spiritual Dimension into Late Modern Healthcare

The development of modern medicine and nursing has been characterised by a close adherence to the biomedical paradigm and by a process of differentiation into subsystems and subdisciplines, each with their own methods and technologies. From a historical perspective, the 20th century marked the fulfilment of what the Hippocratic physicians of the fourth century B. C. had set in motion: an evidence-based medicine, developed according to rational principles. But while Hippocratic therapeutics partially integrated religious practices, modern biomedicine consciously disregards them.

Nevertheless, this is only one side of the story. In order to understand the genesis of late modern spiritual care, we must take a closer look not only at the exclusion of spiritual aspects from healthcare, but also at the varied holistic counter-movements that have accompanied modern medicine from the beginning. Differentiation and reintegration are interrelated in a way that is often overlooked. Precisely because the processes of differentiation and secularisation that characterise modernity are also associated with exclusion, they raise the question how that which has been suppressed can be brought to the fore anew. How can the excluded spiritual dimension be reintegrated and taken into account in a secular healthcare system?

If one understands spiritual care broadly as the professional "recognition of and attention to spirituality within health care"[12], then its roots date back to the first decades of the 20th century. The widespread but mistaken impression that spiritual care is a product of the early 21st century is due to the coincidence that in recent decades different movements have coalesced and formed a new field of interdisciplinary research and practice. Even if it would be an

12 Balboni et al. Spirituality in Serious Illness and Health.

exaggeration to speak of a spiritual turn in healthcare,[13] the last two decades of the 20th century can be regarded as a watershed. Just as the ecological limits to growth increasingly came into view during these decades, so too was it increasingly recognized that an exclusively biomedical approach cannot achieve today's healthcare. Daniel Callahan, who chaired an international commission on this topic on behalf of the Hastings Center in New York, put it as follows: "By the mid-1990s, medicine had become a costly, complex and difficult enterprise that belied the optimism that had dominated the period between World War II and the 1980s."[14] This prepared the ground for a broader rediscovery of the spiritual dimension in healthcare.

In what follows I will explore in greater detail the Christian roots of late modern spiritual care. These historical reflections allow us to step back from the current discussion and help put it in perspective; they will point to a wide range of possibilities and to the seeds of future developments. The Christian call to healing and the relationship between healthcare chaplaincy and the (other) health professions can, as we shall see, be developed in very different directions.

The Christian Roots of Spiritual Care in the 20th Century

Current developments in spiritual care cannot properly be understood without bringing to mind their origins.[15] In tracing these developments, the following pages resemble the inspection of a building site. On what underpinnings can and should chaplains continue to build? The foundations of current attempts to relate healthcare and spirituality must be retrieved from the dust of history. To stimulate

13 For a critical examination of countervailing trends, see Balboni & Balboni, Hostility to Hospitality, 228–239.

14 Callahan, Goals of medicine, 16.

15 A similar point is made by Swift, Hospital Chaplaincy in the Twenty-First Century, 9: "An absent history may be a contributory factor in the crisis of contemporary chaplaincy, emphasising the lack of a clear sense of identity and forward momentum."

and broaden reflection, underappreciated connections will be drawn out and certain misconceptions thereby corrected.

To anticipate some points: the history of modern spiritual care encompasses much more than just the history of palliative care and cannot be equated with a secularisation of Christian spirituality.[16] The history of contemporary spiritual care also includes *Clinical Pastoral Education (CPE),* which must itself be understood in a broader context. It wasn't the initiative of the Reformed theologian Antoin T. Boisen alone, but also of the haematologist and medical reformer Richard C. Cabot. And in the institutionalisation of CPE these two very different men were joined by a highly distinguished woman: Helen Flanders Dunbar. Nor was it the Bangkok Charter of 2005 that first legitimised the inclusion of the spiritual dimension in the context of international health policy, but a much earlier resolution of the World Health Assembly in 1984.

Christian faith-based involvement in global health took on very different forms in the past century, which are more closely intertwined than they first appear. As will be shown in the following vignettes, Christian actors were to be found in different roles and places: at the side of those who advocated the worldwide expansion of modern medicine, but also in all manner of reform movements that were critical of modern medicine.

Clinical Pastoral Education: The initial professionalisation of healthcare chaplaincy

CPE was prepared in the crucible of an interprofessional experiment that developed in the early years of the 20th century and is known to history as *The Emmanuel Movement.*[17] It owes its name to the Boston parish in which it was located. This innovative experiment was initiated by the Reformed theologian Elwood Worcester

16 On the complicated history of the term 'spirituality', see Peng-Keller, Genealogies of 'spirituality'.

17 On what follows, see Powell, Worcester; Myers-Shirk, Helping the Good Shepherd; LaBat, Anton Boisen, 40–43.

(1862–1940) who had studied with Wilhelm Wundt in Leipzig and been influenced by William James.[18]

In 1905, at the request of a doctor friend, Worcester developed a community support service for the poor and those suffering from tuberculosis. To this end, he set up an outpatient care centre that provided pastoral counselling in addition to medical treatment and group therapy services. Soon, the therapy programme was targeted towards people with mental disorders and the spectrum of therapeutical approaches was expanded. At weekly meetings, an interprofessional care team offered psychological and spiritual support to those affected. These weekly meetings, which soon attracted public attention, began with spiritual, medical and psychoeducational lectures, which were accompanied by an invitation to therapeutic treatment, confession, prayer and spiritual exchange.

Religion and Medicine (1908): The Foundations of Interprofessional Spiritual Care

Worcester set out the basis for his innovative attempt to combine psychotherapeutic counselling with spiritual practices in his seminal book programmatically titled *Religion and Medicine.* It was published in 1908 in collaboration with the Anglican theologian Samuel McComb and the Jewish psychiatrist Isador Coriat.[19] The authors see themselves as living in a new epoch of spiritual awakenings: "If the Nineteenth Century was materialistic and critical, the first half of the Twentieth Century promises to be mystical and spiritual." (8) At a time in which the health-promoting effects of "religious and spiritual states" were recognised, the authors attempt to relate spiritual healing and modern science to one another in a reflective way. The Emmanuel Movement, whose praxis the book reflects and for which it provides a foundation, anticipates insights and procedures that would later be found among those of cognitive behavioural therapy and interprofessional spiritual care.

18 LaBat, Anton Boisen.

19 Worcester/McComb/Coriat, Religion and medicine. Their collaboration with the Jewish psychiatrist Coriat attests to the interreligious openness of the Emmanuel Movement. The page numbers in the text refer to this publication.

> The therapeutic methodology that the book develops starts at the mental level. Anxious thoughts are to be replaced – by mindfully opening up to God's presence – with thoughts that give hope and confidence. For mental disorders and alcoholism, there were, according to the authors, the most effective therapies are those that use the power of positive thought. The (auto)suggestive methods inspired by the *New Thought* movement are contextualised in two respects by Worcester and his co-authors: on the one hand, they are placed in the context of scientific psychology, and, on the other hand, in a religious context of interpretation and practice. Theologically, the authors appeal to the Christian call to healing. This call bears emphasis, they urge, as there is a growing number of spiritual healing movements that are just as critical of the church as they are of modern medicine. In contrast, the book advocates a therapeutic pluralism within which modern medicine too is given a certain theological dignity: "God heals through various means" (3) – including those of modern medicine and psychiatry.

One of the doctors who supported the Emmanuel Movement was the aforementioned haematologist *Richard Cabot* (1868–1939), who was responsible for outpatient care at the Massachusetts General Hospital. Cabot links the Emmanuel Movement with the CPE which he co-founded. The impetus for professionalising healthcare chaplaincy came in response to the growing specialisation of clinical work. Thus, in 1905 Cabot, who came from the highest echelons of Boston society,[20] laid the groundwork for clinical social work and set up the first position in this field at Massachusetts General Hospital with his own funds. Cabot's vision of a new form of chaplaincy, which he called "clinical", was based on the experience of interprofessional cooperation with chaplains and the insight that, as medicine is increasingly specialised, doctors are reliant on specialised professionals from other disciplines.

As an advocate of social medicine, Cabot called for medical care to take social context into account as well. Similarly, the spiritual dimension should also feature in interprofessional care: through

20 Cadge, Spiritual Care, 181 (fn. 30).

clinically trained chaplains who collaborate with clinicians and chart their experiences in chaplaincy records. The chaplain's role in this context was primarily to support and to counsel, with the aim of helping suffering people to mature as human beings and to deepen their faith.[21]

As is well known, Cabot did not start CPE on his own. *Anton T. Boisen* (1876–1965), his co-founder, had somewhat different ideas about the chaplain's clinical role. A lifelong sufferer from mental health problems himself,[22] Boisen was more critical of mainstream medicine. While Cabot emphasised the importance of a solid basis in academic medicine and the leading role of the doctor, Boisen sympathised with more unorthodox views and approaches in the name of holistic healing.

Yet another, more psychoanalytical, view was taken by *Helen Flanders Dunbar* (1902–1952), a doctor trained in theology and philosophy and one of Boisen's first students in 1925.[23] Dunbar led the *Council of the Clinical Training of Theological Students* (CCTTS), founded in 1930, in its early years and thus helped determine the fate of the chaplaincy movement with respect to content and politics. Dunbar, who is regarded as the founder of US psychosomatics,[24] had studied philosophy and theology and in 1929 received her doctorate from Columbia University in New York with a highly regarded thesis on Dante's *Divina Commedia.*

At the same time, she studied medicine and completed placements at Vienna University Hospital, with the psychoanalyst Felix Deutsch, and at Burghölzli in Zurich, with Carl Gustav Jung. Dunbar emphasised the relaxing and healing power of religious experiences and the interconnectedness of the physical and mental dimensions. In her conviction that "few patients still need advice on what to do once they are emotionally free to think about their problems",[25] she anticipated a central insight of Carl Rogers.

21 Cabot/Dicks, The Art of Ministering to the Sick.
22 LaBat, Anton Boisen. Boisen was supported in his unorthodox ideas not least by Worcester, ibid. 43.
23 Leas, A Brief History, 1; LaBat, Anton Boisen, 19.
24 See Peetz, Helen Flanders Dunbar – Die Mutter der Psychosomatik.
25 Powell, Helen Flanders Dunbar, 154.

Fig. 1: Dunbar and Boisen (to her right) at a meeting of the CCTTS in 1932. The 30-year-old Dunbar chaired this body for many years, shaping the first phase of healthcare chaplaincy education.[26]

CPE laid the foundation for the further professionalisation of healthcare chaplaincy. It was from CPE circles that there arose the first professional hospital chaplaincy association in the USA, the forerunner of today's *Association of Professional Chaplains,* under the auspices of the *American Protestant Hospital Association.*[27] In his programmatic lecture, held at the annual meeting of this association in 1939, Russell Dicks outlined the future professionalization of healthcare chaplaincy, using the terms of "spiritual needs", "spiritual stress", "spiritual wellbeing" and "spiritual care".[28] CPE, which made the leap to Europe in the 1960s and somewhat later to Asia, is undoubtedly one of the most important sources of inspiration for contemporary spiritual

26 https://acpe.edu/docs/default-source/acpe-history/the-biography-of-anton-theophilus-boisen.pdf?sfvrsn=f542507_2 (16.11.2023).
27 Cf. Cadge, Healthcare Chaplaincy as a Companion Profession.
28 Dicks, Standards of the Work of the Chaplain.

care.[29] It has acted as a catalyst for professional identity formation and spiritual maturation for countless chaplains, including the author of this book.[30]

CPE arrives in Switzerland

Christoph Morgenthaler, who was later appointed to the Chair for Pastoral Care and Pastoral Psychology at Bern University's Faculty of Theology, remembers his first encounter with CPE. It would prove to be decisive for his career: "The 1968 movement reached Bern in 1969. The theological faculty was divided: some were followers of Marx; others of Freud. Academic reform was in the air. The first books on a new form of pastoral care were being published. Heje Faber and Ebel van der Schoot's *The Art of Pastoral Conversation* was one of the books that electrified us at that time. It contained chaplaincy case studies with detailed discussions from the perspective of psychology and psychotherapy. An event was organised to demonstrate the methods and benefits of the new forms of training; and a lecture hall was reserved for this purpose in the Anatomical Institute. Where the dissection table usually stood, a group of chaplains had gathered and, together with Heje Faber, who had flown in from the Netherlands, they were analysing the verbatim of a meeting. In the tiered seating were students, clergymen and a few clergywomen, as well as delegates from the Synod Council, the church leadership, who were there to assess whether something dangerous was coming the church's way, perhaps something even more dangerous than what was coming from the left.

At the table down in the arena, concentrated, unspectacular work on the minutes of a meeting; conscientious exegesis of a 'human document', skilful, modest, low key, and for that very reason spectacular. A new era is dawning. Chaplaincy can be learned! Chaplaincy is exciting! [...] The self-confidence of therapeutically reflective chaplaincy grew stronger despite church disagreements – one began to see oneself as part of a "chaplaincy movement". This was also evident in the founding of the German Society for Pastoral Psychology in 1972, the ecumenical

29 For just one example, see https://cpspphilippines.com/about-us/our-history/.
30 Cf. the personal testimony of Fitchett, CPE and Spiritual Growth.

professional association for pastoral care, counselling and supervision. Standards for training and quality management in chaplaincy were developed and enforced, qualifications in five different sections were formalised and professional guidelines and initiatives developed. The sections were more or less clearly oriented towards particular schools of psychotherapy – psychoanalysis, talking therapy, group therapy – while the overarching debate about the conceptual foundations of chaplaincy was also controversial and lively. The chaplaincy movement reached its institutional form."[31] The form which it took in the case of Christoph Morgenthaler himself is discussed below.

In French-speaking Switzerland, a similar development took place in the last decade of the 20th century. Cosette Odier, who led the hospital chaplaincy at Lausanne University Hospital between 2000 and 2016, encountered CPE during an extended visit to Quebec. This encounter also marked the beginning of an international collaboration that continues to this day and has had a great influence on chaplaincy at Lausanne University Hospital over the last two decades. The focus on the spiritual needs of patients fundamentally changed Odier's understanding of the remit of hospital chaplaincy: "For example, I visited a woman on the day before an operation that she was concerned about. She asked me to pray to St. Rita, the patron saint of lost causes. My Calvinist heart began pounding: Praying to a saint will not help! I should explain to her that it is better to pray to God or Jesus … But my training had its effect. If I wanted to respect this woman, it was necessary to respect her way of living and praying. Taking this approach, which was centred on her and not on me or on what I considered to be the 'right' way of praying, it was necessary that I comply with her request. It was a very moving moment for me as I read with her the prayer to St. Rita, which, fortuitously, she had written on a small card on the bedside table. I have never forgotten this woman, who helped me grasp the inner movement that is necessary for any relationship in which the other is taken seriously."[32]

In 2000 Cosette Odier was commissioned by Lausanne University Hospital to refine their healthcare chaplaincy training programme, which

31 Morgenthaler, Wie hat Psychotherapie die Seelsorgelehre und -praxis verändert, 32 f.

32 Odier, L'accompagnement spirituel en mouvement, 33.

had existed since the 1990s. At the beginning of the new century, healthcare chaplaincy at the hospital was put under the direction of the nursing department. This allocation is reflected in the fact that the chaplains at Lausanne University Hospital, unlike elsewhere in Switzerland, have been wearing white hospital uniforms since long before the Corona pandemic made it obligatory. In 2004, a working group was set up to promote interprofessional cooperation with regard to spiritual care. This ultimately led to the development of an instrument for spiritual assessments, integrating chaplaincy further into interprofessional communication and documentation.[33] Remarkably, this instrument in turn formed the basis for the PC-7-Assessment, which was developed by George Fitchett's research group in Chicago: Spiritual care is developing through close international exchange![34] This can also be seen in the change in the professional self-designation. At the Lausanne University Hospital, the chaplains wear badges that no longer say "aumônier", but "accompagnant:e spirituel:le". This development was facilitated by a constitutional amendment. The new cantonal constitution, adopted in 2003, states that "the spiritual dimension of the person" must be taken into account (Art. 169). As a consequence, state-funded healthcare chaplaincy is no longer a denomination-specific function, but a "jointly performed function".[35] As will be shown in chapter 2, this change to the legal framework is consonant with international developments.

From Medical Mission to the Hospice Movement

Along with the Emmanuel Movement, the medical mission is another largely unrecognised root of contemporary spiritual care. It is all the more important to recall its aims here – without ignoring its colonial entanglements. As with CPE, it was a Christian movement that entered early on into a close alliance with modern medicine and in which a new understanding of the Christian healing mission was initiated. From a historical perspective, it is particularly notewor-

33 Monod et al., Validation of the Spiritual Distress Assessment Tool.
34 See Fitchett et al., Development of the PC-7.
35 Odier, Die französischsprachige Welt, 195.

thy how medical missionaries often transformed conventional role models and goals. Some missionaries were accused of concentrating too much on medical care and neglecting their spiritual tasks. Gender roles were transgressed twice: by the many male nurses, some of whom formed their own congregations, and again by a considerable number of female doctors. The latter were irreplaceable trusted intermediaries for the mission in countries where only women could provide medical care for the female population.

In the first decades of the 20th century, the medical mission was empowered by medical and surgical advances. However, the distinctive synthesis of Western medicine, mission and colonialism involved its actors in numerous conflicts of objectives. While most missionary societies emphasised the priority of spiritual care over concern for physical well-being and regarded medical care as a precursor to evangelising, the missionary doctors themselves tended more towards a medical pragmatism that was compatible with experimental theological ideas similar to those that can be found in Worcester and Boisen.

One example of this is the Canadian doctor *Belle Oliver* (1875–1947), who was active in India. Over the years, Oliver increasingly moved away from instrumentalising medical care for missionary ends. In the books and articles in which she reflected upon her experiences as a missionary doctor, she advocated a holistic understanding of healing that closely interwove medical and chaplaincy concerns. With reference to Jesus's therapeutic practice, for example, she emphasised: "God cares for man in his wholeness – body, soul and spirit […]. His gospel is communicated through service that is in harmony with these channels."[36]

Oliver's ideas were influenced by William Ernest Hocking, who taught philosophy of religion at Harvard and was in turn a student of William James. In 1932, Hocking published a controversial report with the programmatic title *Re-Thinking Missions: A Laymen's Inquiry after One Hundred Years.* The report evaluates existing missionary strategies and argues for a paradigm shift in the theology of evangelism. It recommends involving the local population more in projects, for example, and treating indigenous religions and traditions with

36 As related by Klassen, Spirits of Protestantism, 113.

greater respect. A key sentence, quoted by Oliver, is: "Ministry to the secular needs of men in the spirit of Christ […] *is* evangelism, in the proper sense of the word."[37]

The project of integrating the spiritual dimension into curative, rehabilitative, palliative or preventive health care is common to all the movements and actors mentioned so far. However, the fact that "spiritual care" began, in the middle of the 20th century, to establish itself as the technical term for this project is primarily due to nursing institutions with Christian roots, such as the American *Nurses Christian Fellowship.* This American organisation, which was founded in the mid-1930s and became a national organisation in 1948, not only conducted workshops on the spiritual needs of patients in various states in the 1960s, but also initiated the first research projects in this field. These efforts came to fruition in Sharon Fish and Judith A. Shelly's book *Spiritual Care: The nurse's role,* first published in 1978 and subsequently reprinted several times.[38]

Perhaps surprisingly, *Cicely Saunders* (1908–2005) should also be mentioned in this context. Her way of combining Christian hospice care with modern medicine ultimately transformed both. *St Christopher's Hospice,* which Saunders opened in London in 1967, was – no less than its Christian predecessors – a living space where people prayed together, and spiritual community was fostered. But it also became a place where medical research was pursued, and new pain therapies were tested. Through her work, Saunders brought to the fore a forgotten goal of medicine: the alleviation of pain. In the last decades of the last century, there was a growing understanding that the "the relief of pain and suffering caused by maladies"[39] remains a goal of medicine and that this goal cannot be attained without specialised research and training. By firmly connecting palliative care with interprofessional spiritual care, Saunders not only designed a new model of interprofessional cooperation, but also set the course for the establishment of spiritual care as an essential element of palliative care in global health.

37 Klassen, Spirits of Protestantism, 113.
38 Shelly/Fish, Spiritual Care.
39 Callahan, The Goals of Medicine, 11.

Case study:
Spiritual assessment and digital documentation in Nairobi

In many countries of the southern hemisphere, Christian health institutions, in receipt of financial and staffing support from North American and European churches, still form a pivotal component of the health system. In these institutions chaplaincy is often provided by members of religious orders working in nursing, medicine and social care. The Maryknoll missionary Richard Bauer is one such person. Since 1982 he has worked in various African countries in institutions that support HIV/AIDS sufferers. After training for 18 months at Mount Sinai Hospital in New York to become a CPE-certified hospital chaplain, the Catholic priest returned to Kenya in 2018 as part of the *Eastern Deanery AIDS Relief Program (EDARP)* in order to strengthen the provision for outpatient palliative care in a Nairobi slum with a predominantly Muslim population. In order to take proper account of spiritual needs, Bauer introduced a spiritual assessment, which is administered by *community healthcare workers* and recorded in digital medical records.[40]

The Recognition of the "Spiritual Dimension" in Health Policy

A year after Cicely Saunders opened her hospice in London, the *World Council of Churches* (WCC) established the *Christian Medical Commission* (CMC). This was motivated by a lengthy process of reflection on the future of Christian involvement in global health. Decolonisation had made medical mission questionable in its previous form. The groundwork for a renewed understanding of the Christian mission in healthcare was laid in a 1964 consultation held in Tübingen by the *German Institute for Medical Mission* and the WCC. The participants wrestled with the question whether it was time for the churches to withdraw from healthcare and leave the task to secular institutions. Had the church accomplished its mission in this area? A manifesto published as a result of this consultation took a clear line against any such withdrawal, invoking anew the Chris-

40 For further information, see Peng-Keller/Neuhold, Charting Spiritual Care.

tian call to healing. The key message has already been quoted in the introduction to this book: "The church cannot surrender its responsibility in the field of healing to other agencies."[41]

As a result of a critical confrontation of the colonial past and a growing awareness of global interdependence, a new understanding of the Christian call to healing came to prevail in the WCC. In the process, new emphasis was given to the responsibility Christians share for establishing health systems based on solidarity. New forms of cooperation and coordination with secular actors in global health were sought. Inspired by the insights and ideals of social medicine that had shaped the WHO at its foundation,[42] the collaboration between the CMC and the WHO (which from 1974 onwards was carried out through a joint committee of the two organisations) was itself a model of a new type of cooperation. The CMC advocated successfully for a model of *primary healthcare* influenced by social medicine. The concern for equitable healthcare was combined here with an integrative, culturally sensitive and participatory approach, integrating traditional healers and community workers.

This health programme also formed the framework within which in 1983, for the first time its history, the WHO explicitly and thoroughly discussed the question how it should integrate the spiritual dimension.[43] The initiative for this was seized by *Samuel Hynd* (1924–2016), the Minister of Health of Swaziland. He personified the transition that the CMC stood for. Hynd's father was as a Scottish medical missionary and had worked for decades building up the health system on the European model. Samuel Hynd, who followed in his father's footsteps and shared his convictions, demanded that the spiritual dimension be recognised in future WHO programmes. The WHO definition of health was incomplete, he said, because it fails to mention the "spirit", which is a crucial factor for engagement in global health.

41 World Council of Churches, Witnessing to Christ today, 14.

42 For more detailed information see Peng-Keller/Winiger/Rauch, The Spirit of Global Health, 17–25.

43 On the following, see Peng-Keller/Winiger/Rauch, The Spirit of Global Health, 42–61.

The discussion triggered by Hynd reflects the constellation of powers and interests that, despite significant shifts, still determines world health policy today. While the representatives of Western states were largely critical and those from communist countries opposed it, Hynd's initiative received the support of the Arab states. The fact that the resolution was ultimately adopted is thanks to the commitment of the Gulf states and the then Director General Halfdan Mahler.

Case study: Holistic models of health at the WCC and the Vatican

The idea formulated by Hynd, that the biopsychosocial understanding of health should be expanded to include a spiritual dimension, was taken up by both the World Council of Churches and the Catholic Church. In 1982 the CMC had published the study *The Search for a Christian Understanding of Health, Healing and Wholeness,* the final part of which contains a definition of health which is later taken up several times in WCC documents and which explicitly ties in with that of the WHO. According to this definition, health is a "dynamic state of well-being of the individual and society; of physical, mental, spiritual, economic, political and social well-being; of being in harmony with each other, with the material environment, and with God".[44] A similar definition was reached by Pope John Paul II in 2000. He speaks of a "vision of health, based on an anthropology that respects the whole person, far from being identified with the mere absence of illness, strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level. In this perspective, the person himself is called to mobilize all his available energies to fulfil his own vocation and for the good of others."[45] In chapter 4 I shall come back to these discussions.

44 WCC, The Search of a Christian Understanding of Health, Healing and Wholeness, 17.

45 VIII World Day of the Sick, 2000 | John Paul II (vatican.va) (21/11/2023).

The Institutionalisation of Spiritual Care in Healthcare

As a more or less structured area of research and practice, interprofessional spiritual care is the result of a confluence of different currents. Among the various factors, palliative care had a key role in this process. Over the course of the 1980s and 1990s it gradually permeated the WHO. As a component of palliative care, spiritual care has also been recognized worldwide as an interprofessional task in healthcare.

In the late 1980s, a further factor emerged: the strong growth of empirical research on health and spirituality. The empirical study of health-related aspects of religiosity, which began in the late 19th century with William James and Edwin Starbuck, intensified towards the end of the 20th century and now covers almost all areas of healthcare. This upsurge of a new field of study was associated with an academic institutionalisation of spiritual care. Duke University, for example, established a *Centre for Spirituality, Theology and Health* as early as 1998, on the initiative of the psychiatrist Harold Koenig and with the support of the Templeton Foundation. At the same time, North American and European theological faculties developed new Master's programmes to provide the groundwork for specialised chaplaincy in public institutions.[46] Particularly noteworthy are the developments in Ontario, where there are now three theological faculties offering qualifications in spiritual care and psychotherapy.[47] These degrees are recognised by the professional association of registered psychotherapists. Graduates can train to become state-approved 'spiritual care providers' and 'psycho-spiritual therapists' and work as health professionals. Thomas O'Connor comments: "The fact that the College of Registered Psychotherapists of Ontario (CRPO) accepts spiritually integrated psychotherapy as an approved modality indicates a significant shift. […] The notion of a spiritual care provider (chaplain) in private practice is new in Canadian society. […] Previous to CRPO, private practice chaplain was an oxymoron."[48]

46 For an overview of such developments in the USA, see Cadge et al., Training Spiritual Caregivers; Zock, Chaplaincy in the Netherlands.

47 An overview is given by O'Connor, Meakes, Three Emerging Spiritual Practices.

48 Ibid. 282.

Summary
Looking back at the Christian roots of spiritual care in the 20th century, we see manifold forms of involvement in the rapidly changing field of healthcare across the world. When the history of modern medicine is presented as a success story of Western science and technology, the transformative influence of Christian actors and movements gets lost. As much as Christian engagement with healthcare was characterised by colonialism until well into the 20th century, it has increasingly adopted a universalistic ethos, leading to new and by no means homogeneous forms of spiritual care.

Forms and Models of Contemporary Spiritual Care

What connects the 20th century forms of Christian spiritual care with current approaches is their holistic, antireductionist aim: to correct the exclusionary tendencies of biomedical approaches by addressing the needs of suffering people in a more comprehensive way. Opinions differ, however, when it comes to defining concepts, care models, and responsibilities.

In order to survey current models of spiritual care, I shall draw on a typology given by the Australian sociologist Bruce Rumbold. As with any typology, it reduces complexity. Indeed, many chaplains would feel at home in more than one of the following models. Rumbold differentiates between the clinical, the social and the holistic models. Due to their diverging presuppositions, each of these models conceptualises spiritual care in its own way.[49] The first model can be understood as an extension of the biopsychosocial model of health. The second one, with an emphasis on voluntary commitment, focuses on caring communities. The third is guided by the distinction between biomedical cure and spiritual healing. There is a plurality of variants of all three models.

49 Rumbold, Models of spiritual care.

Model 1: Clinical conceptions of spiritual care

The clinical model of spiritual care is determined by the goal of interprofessional cooperation and clinical integration. It currently occurs in three main variants. The first one has a generic concept of spirituality and spiritual care. In this first variant (generic) spiritual care is distinguished from (denominational) religious care. An example is the approach of NHS Scotland, described in more detail below. In the second variant, spiritual care refers primarily to an interprofessional field of research and practice to which all professional groups can and should contribute. Here it is left open who has which role within this field. The third variant distinguishes different forms of spiritual care and professional responsibility.

The clinical model has healthcare institutions as its context and the spiritual needs of patients and their relatives as its focus. Spirituality and religiosity are seen as a potential resource or possible hindrance for healing and coping processes, and thus should be included in therapeutic and palliative planning where possible. Insofar as chaplaincy contributes to palliative, curative, rehabilitative and preventive goals, it operates within the framework of this model.

Critics of this model point to the tension between clinical and spiritual goals and the imperative not to instrumentalise spiritual practices for medical purposes. However, in its orientation towards the needs and resources of individuals, the clinical model is in line with the trend towards an individualised spirituality.[50] It is this aspect which has drawn criticism from advocates of a community-oriented model of spiritual care.

Model 2: Social conceptions of spiritual care

Sociological discussions, in particular, have drawn attention to the possible narrowness of clinical conceptions of spiritual care. They problematise the tendency to disregard the community and social contexts of spiritual practices and beliefs.[51] Social conceptions of spiritual care, in contrast, put the focus on the (non-)embeddedness

50 Heelas, Spiritualities of Life.

51 Walter, The ideology and organization of spiritual care.

of vulnerable people. In doing so, they can draw on Cicely Saunders. The idea of hospitality that guides the modern hospice movement is imbued with an ethos of solidarity, of all-inclusive community. Dying people should feel part of a "community of the unlike", which includes professionals as well as volunteers. The health policy of the WCC, already outlined, takes a similar position.

Within the current debate, a community-oriented spiritual care approach has been advocated by, for example, Michael and Tracy Balboni and by Allan Kellehear.[52] Going against the trend of conceptualising spiritual care as a new *(inter-)professional* task and entrusting it to clinical professionals, Kellehear emphasises the responsibility of society for such a practice. While representatives of clinical-therapeutic approaches advocate the professionalisation of spiritual care, the importance of volunteers is emphasised in the social model.[53] The Christian practice of the laying on of hands may be seen in this context as a symbolic act, through which the palliative power of community is communicated to sick people in a tangible way. At present, however, the laying on of hands is more closely associated with those spiritual care models that might be classed as "energetic".[54]

Model 3: Energetic conceptions of spiritual care

The third group is the most heterogeneous of all. It includes charismatic and Pentecostal approaches, as well as those with an affinity for alternative or complementary medicine. Worth mentioning here are forms of chaplaincy that revive the laying on of hands or experiment with imaginative techniques. There is an emphasis on the energetic moment, which is understood either pneumatologically or vitalistically.[55] A German example is Manfred Josuttis' "energetic chaplaincy".

52 Balboni/Balboni, Hostility to Hospitality; Kellehear, Compassionate Cities.

53 See, e. g., the community-based pilot project described in Jakob/Weyel, Spirituality, Mental Health, and Social Support.

54 Rumbold talks of "holistic models", but the first and second models can also claim to be holistic in their own ways, and the energetic model itself can be criticised for being insufficiently holistic.

55 Brown, Healing Gods.

He situates it in the context of current alternative and complementary medicine movements and refers to Jesus' "acts of power".[56]

Energetic approaches call for allopathic medicine to be complemented in at least two ways: firstly, through spiritual healing practices, such as prayer for healing or the laying on of hands; and secondly, through special attention to illnesses that affect not the body, but the "spirit". The emblematic figure here is the healer as a mediator who places himself or herself at the service of a spiritual reality and represents it. In energetic models, spiritual care is carried out less through counselling than in the form of pre- or transverbal practices.

Discussion of models at a chaplaincy meeting

The spiritual care models just presented were discussed at a meeting of healthcare chaplains. The chaplains were asked to indicate which of the models came closest to their understanding of health, healing and chaplaincy. Each of the three models had its sympathisers, although most found it difficult to restrict themselves to a single model. Questions were raised about the anointing of the sick: Can it be assigned to one of the models? Or does it contain elements of all three, depending on its form and theological underpinnings?

The three basic models (which correct or complement each other and can, to some extent, be combined) have different theological affinities. While the first model is found primarily in liberal theological traditions[57] and the second has, for decades, been the guiding model of the hospice movement and the WCC, the third can draw on charismatic approaches, among others. Or, put pneumatologically: If, according to the first model, the Spirit acts – in manifold mediations, not least by health professionals and chaplains – by motivating and giving meaning, according to the second it appears as a force that heals the wound of exclusion and forges a new com-

56 Josuttis, Religion als Handwerk, 181.
57 See Klassen, Spirits of Protestantism.

munity. The third model, on the other hand, places the charismatic and energetic moment centre stage.

The Spiritual Dimension of Health

If one looks for a common denominator of the three models outlined, it can be found in the idea that the biopsychosocial model of health needs to be with a fourth dimension. It is significant to speak here not of an add-on, but of another dimension.[58] A further dimension is much more than merely the inclusion of extra health determinants. It is about opening up a hitherto unrecognised depth dimension of the biopsychosocial model. This further dimension is not reducible to the other three, but to be found *within* bodily, mental and social phenomena. Further empirical research is required in order to specify the precise nature of this depth dimension and its relationship to the other dimensions. The variety of attempts to define the abstract term 'spirituality' reveals a plurality of heterogenous concepts (see next chapter). Empirical research into narrower terms, such as 'spiritual struggle', 'spiritual pain', 'spiritual resources' or 'spiritual wellbeing', however, has been more successful. This counters the idea that the clarification of the umbrella term 'spirituality' is necessary for the narrower terms mentioned. It may be, rather, the other way round: that the latter terms substantiate what is meant by the 'spiritual dimension of health'.

An example of this is provided by the module on spirituality, religion and personal beliefs (SRPB), a supplementary and validated instrument attached to the WHO's quality-of-life questionnaire (WHOQOL). Resulting from a large, cross-cultural survey (the largest of this kind until now[59]), the WHOQOL-SRPB identifies eight facets of 'spiritual wellbeing' (as an aspect of health-related quality of life).[60] Despite the reference to 'personal beliefs' in its name, the

58 Cf. Tillich, Dimensions, Levels, and the Unity of Life.

59 For an overview: Winiger, Spirituality, Religiousness and Personal Beliefs in the WHO's Quality of Life Measurement Instrument (WHOQOL-SRPB).

60 Peng-Keller, Winiger, Rauch, The Spirit of Global Health, 211–215.

instrument does not focus primarily on beliefs, but rather on experiences and attitudes. The eight facets are:

1. Connectedness to a spiritual being or force
2. Inner peace/serenity/harmony
3. Meaning of life
4. Hope & optimism
5. Awe
6. Faith
7. Wholeness & integration
8. Spiritual strength.[61]

The coherence of this cluster is likely a result of mutual reinforcement. For instance: experiences of connectedness, of meaningful life or of wholeness, as well as attitudes like hope or faith, tend to promote inner peace and spiritual strength.

Summary

In this chapter, spiritual care – as the inclusion of the spiritual dimension in health care provision – has been presented in two ways: First, looking back at the previous century, the roots of today's Spiritual Care were displayed (the most important dates are listed in an appendix). This revealed a complex network of independent but mutually invigorating Christian initiatives and movements, which in the late 20th century gradually led to the official recognition of the spiritual dimension in health policy and a growing institutionalisation of interprofessional spiritual care. The chaplaincy movement, which started in Boston in 1925, is part of this network. What characterises clinical spiritual care approaches today could already be found in the CPE at the outset: an interprofessional orientation, a demand for empirical research and quality management. And yet the founding figures of CPE – Cabot, Boisen, Dunbar – were guided

61 WHOQOL SRPB Group, A Cross-Cultural Study of Spirituality, Religion, and Personal Beliefs.

by different models of health. Even within the CPE, diverse forms of spiritual care have been countenanced from the very beginning.

The distinction introduced in the second step, between clinical, social and energetic models and their subtypes, served to give an initial overview of the variety of positions held today – even in church circles. A systematic examination of these different perspectives regarding Christian commitment to healing can be found in chapter four.

The next chapter broadens the scope of our investigation to include two facets of social change that are primarily outside the domain of healthcare, but which have greatly influenced the developments in the field of spiritual care just outlined: religious and spiritual pluralisation, and the shift in the relationship between the state and religious communities.

2 Fluid Spiritualities and Social Change

> "Like social issues in the 19th century,
> and sexual issues in the 20th and 21st centuries,
> the spiritual question has emerged
> in the wake of a social and cultural movement."[62]

Certain social and political developments, to be examined more closely in this chapter, have favoured the rediscovery of the spiritual dimension in global health. Key among these are the diversification of religious and spiritual beliefs and practices, the de-privatisation of the religious, and the emergence of an understanding of "spiritual" that undermines the distinction between the religious and secular spheres. Jürgen Habermas has suggested that this new socio-political constellation be described as *post-secular*. What was traditionally called 'religion' now appears in new forms in secular institutions. This greatly affects healthcare chaplaincy.

The Diversification of Religion and Spirituality

The usage of the term 'spirituality' has expanded greatly over the course of the 20th century,[63] and with it the range of ways in which one can understand oneself as spiritual. To describe oneself or others as spiritual is often to relativise the modern contrast between religious and secular beliefs. Those who use the term 'spiritual' as a self-designation today are not necessarily saying anything about their relationship to religious institutions and traditions. Though the idea of a strict separation of the religious and secular spheres is a characteristic of modernity, the possibility of a secular spirituality emerged at the very beginning of the modern age. Take, for example, mesmerism, a medical and therapeutic reformist movement at the turn of the 19th century, which advocated a thoroughly secular spirituality. It is no coincidence that the German term for 'spirit-

62 Jobin, Spirituality in the Biomedical World, 2.
63 Cf. Peng-Keller, Genealogies of 'spirituality'.

uality' ('Spiritualität') first appears in this context (while the English term arises around the same time in Christian writings[64]). The physician *Johann Heinrich Rahn* (1749–1812), who worked at the predecessor institution to Zurich University, uses this word in his 1789 discussion of mesmerism, published under the title *Sympathy and Magnetism*. According to Rahn each human being is their own individual mixture of "spirituality and animality", whereby it is the former that distinguishes humans from the animals.

The concept of spirituality owes its current popularity not least to the increasing restriction of the concept of religion to the institutional. In his 1902 *The Varieties of Religious Experience,* which strongly influenced the founders of CPE and 20th century spiritual care, *William James* defines the central theme of his book as that of "personal religion", as opposed to the institutional and theological aspects of religion. He is concerned with "the inner dispositions of man himself which form the centre of interest, his conscience, his deserts, his helplessness, his incompleteness"[65] and thus, ultimately, with "human nature", as the subtitle of his book indicates (*A Study in Human Nature*). There are also non-theistic forms of what James discusses under the heading of "personal religion". The American transcendentalists Ralph Waldo Emerson and Walt Whitman, in particular, play an important role for James (and later on for Carl Rogers),[66] as does the Mind Cure or New Thought movement, which he treats in detail in two of his lectures. As such, the meaning of James's "personal religion" is largely consistent with contemporary usage of the term 'spirituality'.

What is currently described as religious and spiritual diversity, spiritual hybridisation, "fluid religion",[67] or multiple belonging[68] is, from a historical perspective, anything but new. What is new, however, is the wider establishment of these trends, which can be seen in the increasing popularity of describing oneself as "spiritual, but

64 Cf. Peng-Keller, Genealogies of 'spirituality', 90.
65 James, The Varieties of Religious Experience, 30.
66 Cf. Fuller, Spiritual, But Not Religious.
67 Lüddeckens/Walthert, Fluide Religion.
68 For careful differentiations see: Berghuijs, Multiple Religious Belonging in the Netherlands.

not religious".[69] This development is a form of globalisation characterised by the worldwide circulation of spiritual and religious ideas and practices.[70] While modernity is characterised by the need to decide between a religious and a secular life orientation, there is now, within the space of (post-)secular society, a burgeoning spectrum of options which often do not belong exclusively to one tradition, but draw on many. These, in turn, extend into the sphere of traditional religiosity, such that the boundaries between "religious" and "secular" are blurred. According to John Cottingham the term 'spirituality' is perfectly suited for our collective situation:

> "The concept of spirituality is an interesting one, in so far as it does not seem to provoke, straight off, the kind of immediately polarised reaction one finds in the case of religion. This may be partly to do with the vagueness of the term […] Yet at the richer end of the spectrum, we find the term used in connection with activities and attitudes which command widespread appeal, irrespective of metaphysical commitment or doctrinal allegiance. […] In general, the label 'spiritual' seems to be used to refer to activities which aim to fill the creative and meditative space left over when science and technology have satisfied our material needs. So construed, both supporters and opponents of religion might agree that the loss of the spiritual dimension would leave our human existence radically impoverished. […] Spirituality has long been understood to be a concept that is concerned in the first instance with activities rather than theories, with ways of living rather than doctrines subscribed to, with praxis rather than belief."[71]

Despite all the individualisation and hybridisation, spiritual pluralisation is not haphazard. Rather, a limited number of basic types of contemporary spirituality are emerging. Nancy Ammerman distinguishes three types (they can also be found under different names

69 Cf. Fuller, Spiritual, But Not Religious.
70 Borup, Pizza, Curry, Skyr and Whirlpool Effects.
71 Cottingham, The Spiritual Dimension, 3.

in William James's *Varieties*).[72] She assigns to the first type all those forms that are defined by an explicit reference to God. The second group consists of those forms that deny any reference to God but affirm a belief in something "higher". The third type is characterised by a belief in "horizontal transcendence", where this may be construed in humanistic or cosmologic terms. The following statement from an atheist woman suffering from cancer serves to illustrate this third type. She describes a state of spiritual well-being in the midst of illness and suffering:

> "So when I've been out in nature, first and foremost, I felt I was myself, that there was time for thoughts, it was peaceful, everything else disappeared. Whatever happens in the world for me or others, nature is still there, it keeps going. That is a feeling of security when everything else is chaos. The leaves fall off, new ones appear, somewhere there is a pulse that keeps going. The silence, it has become so apparent, when you want to get away from all the noise. It is a spiritual feeling if we can use this word without connecting it to God, this is what I feel in nature and it is like a powerful therapy".[73]

Ammerman's typology can be further differentiated. On the basis of extensive empirical data, Heinz Streib, Ralph W. Hood and colleagues[74] distinguish the basic forms of contemporary spirituality with regard to their ideas of transcendence *(theistic vs. non-theistic),* their relationship to institutional forms of religion *(close to religion vs. distant from religion)* and their primary form of self-transcendence *(mystical vs. humanistic).* If one applies these distinctions to the statement above, it represents a spirituality that is non-theistic and distant from religion, and which exhibits a clearly mystical charac-

72 Ammerman, Spiritual but not religious.

73 Ahmadi, Culture, religion, and spirituality in coping, 73. Another example of secular spirituality can be found in Václav Havel's famous letters to his wife, Olga, during his four-year imprisonment at the hands of the Czechoslovak authorities.

74 Streib/Hood, Semantics and Psychology of Spirituality.

ter. If the three types described by Ammerman are transposed into Streib & Hood's coordinate system, the following picture emerges:

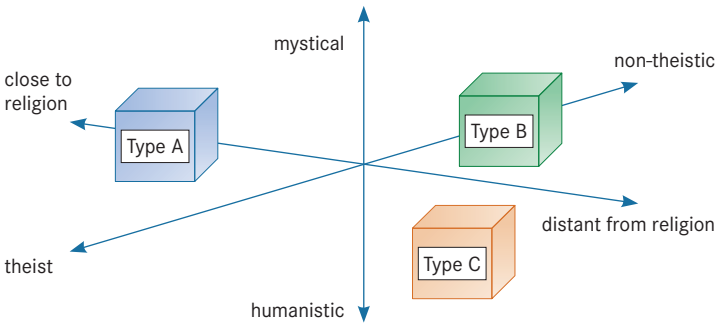

Fig. 2: Types of contemporary spirituality. According to H. Streib and R. W. Hood these appear in forms that are more or less religious, theistic or non-theistic, and more mystical or more humanistic.

As helpful as such typologies may be for providing an initial orientation in the sometimes confusing field of religious and spiritual convictions and practices, they should nevertheless be treated with caution. Typological approaches tend to underplay ambivalences and ossify exploratory movements into fixed positions. Neither the developmental dynamics nor the inner tensions of actual spiritual profiles are adequately represented in such rough cartographies.

Trajectories of spiritual exploration and transformation can be found today in both religious and secular variants. They are often sparked by an encounter with serious illness and death and move beyond previously unquestioned ideas and practices. Tomas Halík, who has studied them with particular care, notes that "seekers among believers (those for whom faith is not a legacy, but a way) and among nonbelievers, who reject the religious notions put forward to them by those around them but nevertheless have a yearning for something to satisfy their thirst for meaning."[75] The function of this appeal to the vocabulary of the spiritual is often precisely to "describe experiences

75 Halík, Christianity in a time of sickness.

and denote positions and aspirations that are 'more than' or 'move beyond' either secularity or religion".[76] In this sense, "spiritual" points towards a sphere that both presupposes and transcends the religious/secular duality typical for Modernity.[77]

There are some paradoxical aspects of contemporary "spiritualities of life",[78] for example, the simultaneous emphasis on intense relationship to the sensual world and a trans-sensory inner orientation: "Rather than being flatly individualistic or purely 'internal' in nature, spirituality appears today to designate an ensemble of (often disparate) technologies – linguistic, ritual, praxilogical, associative, etc. – through which inner and outer worlds are connected."[79] We will return to the therapeutic connections alluded to here.

Healthcare chaplaincy has responded to these cultural and terminological shifts at the macro, meso and micro levels through conceptual reframing. At the macro level, we have seen the renaming of pastoral care organisations. The *Canadian Association for Pastoral Practice and Education,* for example, decided in 2010 to rename itself the *Canadian Association for Spiritual Care.*[80] This change is also reflected in the organisations' publications. The US *Association of Professional Chaplaincy,* for example, launched a journal in 2006 with the ambiguous title *Healing Spirit.*[81] And the *Spiritual Care Association,* founded in San Diego in 2016, chose the entirely de-theologised title *Caring for the Human Spirit* for its journal. Analogous renamings can also be observed at the meso level. One example is the former Pastoral Care Department of Ceders-Sinai Medical Center, which describes itself as follows on its website, aimed at patients and visitors: "Spiritual Care. Healing the Whole Person, Body and Soul".[82]

This diversification of the religious-spiritual field is most noticeable at the micro level of everyday chaplaincy practice. As Wendy Cadge and Emily Sigalow have observed, healthcare chaplains nav-

76 Taves/Bender, Introduction, 6.
77 Cf. Berger, The Hospital, 410.
78 Heelas, Spiritualities of Life.
79 Bender, McRoberts, *Mapping a Field, 10.*
80 Cf. O'Connor/Meakes, Three Emerging Spiritual Practices.
81 Cadge, Healthcare Chaplaincy as a Companion Profession, 46.
82 https://www.cedars-sinai.org/patients-visitors/spiritual-care.html (16.11.2023).

igate the pluralised life-worlds of their patients with the aid of two different communication strategies: on the one hand, by using religiously neutral language; and on the other hand, by moving back and forth between different forms of language, a kind of code-switching.[83] These communicative strategies reflect a specific challenge that chaplaincy faces in pluralistic contexts: the task of dealing with indeterminacies and ambiguities in a caring relationship. However, the term 'spirituality' can itself become a problem, as in the following case study from Hong Kong.

Hong Kong: Christian chaplaincy in the Chinese context

Hong Kong is of particular interest in this connection as "the city is more religiously diverse than anywhere in the U. S. or western Europe, home to the Chinese *san jiao* ('three teachings') of Buddhism, Daoism, and Confucianism, as well as large minorities of Muslims, Hindus, and Christians".[84] Although Christians make up only about 10 % of the population, chaplains in Hong Kong's healthcare system are, for historical reasons, predominantly Christian and funded by church organisations. Like their North American and European colleagues, they usually have a CPE qualification. On the part of the health system, chaplaincy work is legitimised not least through the objective of providing comprehensive healthcare.[85]

In their analyses of healthcare chaplaincy in Hong Kong, carried out in parallel, Simon Shui-Man Kwan and Peter Youngblood draw attention to the fact that chaplaincy work not only takes place against amidst cultural tensions but is also complicated by the legacy of colonialism. Kwan illustrates the communicative difficulties chaplains face with the following transcript of one of his students. The student completed a clinical placement in a Hong Kong hospital, during which she spoke with a 75-year-old patient of Chinese heritage.

83 Cadge/Sigalow, Negotiating Religious Differences.
84 Youngblood, The Problem of Global Interfaith Chaplaincy, 330.
85 Kwan, Negotiating the meaning of spirituality, 21; Nursing Council of Hong Kong, Core-Competencies for Enrolled Nurses.

"Chaplain: Good morning, Ms. Chan. My name is So Siu An. People here call me Ms. So. I am the hospital chaplain. Are you fine today?

Patient: Fine? Not fine. If I am fine, I won't be hospitalized. Chaplain? Oh, my son is a Buddhist, I won't need Christianity.

Chaplain: Oh! You may rest assured that I am not here to evangelize. I am a lingxin guanguyuan. (In English, spiritual care worker. Literally, 'ling' in Chinese is spirit or soul, 'xin' is nature, 'guanguyuan' is care giver).

Patient: Spiritual care? I am here only because of bone fracture. My disease is not terminal. (For a traditional Chinese with very little Western education, lingxin would subconsciously mean something relating to the concept of ghost.)

Chaplain: Oh no! I mean I call on you to take care of your xinling. (Literally, heart- spirit; in English, spirituality, or soul).

Patient: I don't quite understand what you mean. Are you a psychologist? (The literal translation for 'psychology' in Chinese is 'heart-principle-study.' [...])

Chaplain: No ...

Patient: Then, what do you do?

Chaplain: I am here to chat with you, befriend with you, and if any patients here would feel lonely, or hopeless because of their illness, or are unable to see the meaning of life, and so on, I am here to comfort them.

Patient: But ... you said you are a spiritual care worker? I am confused ...

At this moment, a nurse approached Ms. Chan.

Nurse: Great, Ms. Chan, you look so jingshen baoman (In Chinese, 精神飽滿, meaning, full of spirit) today! It's time to measure your temperature.

Patient: (Happily smile) Definitely! I am now strong enough to kill at least several tigers! (A Chinese metaphorical expression that predominantly refers to a very good body condition).

Chaplain: I'll visit you again later.

Patient: Oh! That is not necessary. Thank you very much."[86]

86 Kwan, Negotiating the meaning of spirituality, 17 f.

> Despite the chaplain's best efforts to explain her role, Ms Chan finds it difficult to classify her correctly. Does she want to proselytise? Is it about preparing for approaching death, something that Ms Chan does not want to concern herself with ("Spiritual care? I am here only because of bone fracture. My disease is not terminal.")? Or is it just a linguistic misunderstanding? Kwan interprets these communicative difficulties in the context of postcolonial studies as representative of the "deep conflict between a Chinese/Asian conception of spirituality/soul and its Western counterpart",[87] although he immediately puts this dualistic comparison into perspective by pointing out that there are in "the long history of Chinese culture [...] not one, but many anthropologies".[88] Precisely because this is also the case for its "Western counterpart" and because "religious circulations" between West and East have for some time led to considerable "whirlpool effects",[89] chaplains in European and North American health institutions face comparable communicative difficulties when they introduce themselves as spiritual care givers who offer neither denominational chaplaincy nor simply psychological counselling.

Religious and spiritual pluralisation is only one aspect of the broader social changes that are relocating chaplaincy within healthcare systems. It is to be distinguished from the readjustment of the relationship between the state and faith communities, to which I shall turn in the next section.

Healthcare Chaplaincy in a (Post-)Secular Age

Chaplaincy in public institutions is not only confronted with growing religious-spiritual diversity, but also has to deal with changing socio-political conditions. These can roughly be described as forming a trend towards a post-secular order. In his acceptance speech for

87 Kwan, Negotiating the meaning of spirituality, 21.
88 Ibid., 23.
89 Borup, Pizza, Curry, Skyr and Whirlpool Effects.

the 2001 Peace Prize of the German Book Trade, Jürgen Habermas observed that secular societies must find a new way of adjusting to the persistence of religious institutions and self-interpretations.[90] In a post-secular society, the separation of state and religion is not questioned, but the relationship between the two must be revisited. The new cantonal constitution of the Swiss canton of Vaud is a remarkable example of this. Here, the traditionally close relationship between the state and the Reformed Church has been transformed into a newly regulated and positive relationship with those communities have a community-minded approach to care for the "spiritual dimension". As a profession that is operative in both the religious and the secular fields, healthcare chaplaincy is given a pivotal role in a post-secular society. Despite the increasing economisation of the healthcare sector, the number of hospital chaplains has, in some places, risen significantly over the last two decades.[91] This can be seen as an indication of the growing importance of healthcare chaplaincy; as can international efforts to establish it as an independent profession in the healthcare sector, in response to the new socio-political situation.[92]

In a post-secular society, the question which form of chaplaincy in public clinics deserves state support is linked to two interrelated questions, each requiring a political response. On the one hand, there is the question of diversity management in public institutions, and on the other, the question of whether it is appropriate that the religious affiliations of professionals should be (in)visible in, for example, dress or symbols.

USA: State-sponsored healthcare chaplaincy?

Probably the most detailed study to date of the repositioning of chaplaincy in public institutions was conducted by the US legal scholar and theologian Winnifred F. Sullivan. It will be seen that her anal-

90 Habermas, Glaube und Wissen. For the entire discussion, see Schmid, Postsäkularität als Leitperspektive theologischer Sozialethik. That this also applies to a country like Spain is shown by Griera/Martínez-Ariño/García-Romeral, Beyond the separation of church and state.

91 Cage/Skaggs, Chaplaincy, 11.

92 Schützeichel, Seelsorge im Wohlfahrtsstaat.

ysis of the situation in the US, which draws on landmark rulings by US courts, also applies to Canada, Australia and Western Europe. Among Sullivan's case studies, that involving the *US Department of Veterans Affairs* (VA) is particularly instructive.[93] With over 5 million patients and the largest national training programme for health professions, the VA is one of the most important US health institutions and has a unique position due to its connection with the US Army.

The court case investigated by Sullivan also relates to this special status. An association of secularists had argued that state funding for chaplaincy within the VA violated the constitutional requirement of neutrality in matters of religion. The court responsible for this case dismissed the complaint on the grounds that the services in question were not about religious support in the narrow sense, but about comprehensive healthcare, to which a patient-centred integration of the spiritual dimension belongs. Spirituality is not necessarily bound to a religious denomination, according to the ruling, but also includes questions of the meaning of life. These are also significant for patients with no religious belonging.

In her analysis, Sullivan shows that the plaintiff and the court presuppose different understandings of chaplaincy. While the association of secularists thinks of chaplaincy as something denominational, the court understands it as a specialised profession in healthcare. The published judgement outlines exactly what such chaplaincy involves: a thorough assessment and evaluation of the spiritual needs of patients, a high degree of integration into comprehensive healthcare provision and close cooperation with health professionals.[94] From the court's perspective, what makes state support for healthcare chaplaincy constitutional is its compliance with medical objectives: the provision of curative, rehabilitative and palliative support to patients.

93 Sullivan, A Ministry of Presence.

94 Sullivan, A Ministry of Presence, 39.

The Karlsruhe judgement concerning palliative complex therapy

The Karlsruhe Social Court argued similarly in its 2019 ruling on the financing of chaplaincy in the context of palliative care. St. Vincentius Clinics had filed a lawsuit against a health insurance company that refused to recognise chaplaincy consultations as part of palliative complex therapy. The court case lasted eight years in total. A Catholic chaplain, who was part of the interprofessional team, had given support to a patient suffering from chronic lymphocytic leukaemia over the course of three weeks and recorded a workload of 90 minutes. The insurance company refused to cover the costs for this, arguing that the "chaplaincy work could only be classified as care in the spiritual/religious sense. A chaplain is subject to the duty of confidentiality and is therefore not a healthcare professional".[95]

The court found in favour of St. Vincentius Clinics and pointed out in its ruling that, according to the definition of the World Health Organisation, the consideration of spiritual needs is part of palliative care. Therefore, chaplaincy was an integral part of palliative care. The Karlsruhe Social Court points to a changed understanding of chaplaincy: "In contrast to the traditional understanding of hospital chaplaincy as a complementary service independent of treatment, chaplaincy in the palliative context assumes its share of responsibility in the treatment plan."[96] It is also emphasised that "as an autonomous occupation of a spiritual nature" chaplaincy has a distinct character in comparison to psychotherapy.[97] What this consists of is explained in detail: "This [= the responsibility of chaplaincy in palliative care] happens through the precise identification of spiritual stress factors and resources. The aim is to include the spiritual and existential dimension of suffering and quality of life in multimodal therapy planning. The addressees of this are patients and relatives as well as the entire team. The participation of chaplains in multidisciplinary team meetings and supervisions shows that it is natural to integrate chaplaincy. Services are routinely documented in patient documentation, while respecting chaplaincy

95 Sozialgericht Karlsruhe, Urteil S 9 KR 1621/17, 48 f.
96 Sozialgericht Karlsruhe, Urteil S 9 KR 1621/17, 47.
97 Sozialgericht Karlsruhe, Urteil S 9 KR 1621/17, 47.

> confidentiality [...]."[98] By reference to the WHO and the German Society for Palliative Medicine, the Social Court of Karlsruhe spells out the legal consequences of what was described above as the reintegration of the spiritual dimension into healthcare.

According to Sullivan a *new governance in religious affairs* is developing in parallel to the legal reformatting of state-supported chaplaincy. Increasingly, it is secular institutions that decide whether someone meets the requirements to be employed as a chaplain in a public institution. The developments described by Sullivan are the result of gradual social change that is not limited to the USA, but observable internationally, as can be seen if we turn to our attention to other countries.

Canada: Healthcare chaplaincy in the context of "open laïcité"

In the Canadian province of Quebec, whose health system had a deeply Catholic influence until well into the 1960s, the transformation of the religious field led to new professional roles and titles. The key points will be familiar from the account of Cosette Odier: In Quebec's healthcare system, the term "aumônier", which is still used today in France and French-speaking Switzerland for healthcare chaplains, was replaced as early as the 1970s by the term "agents de pastoral". This name change reflected the fact that Canadian healthcare chaplaincy was increasingly carried out by non-ordained Catholic chaplains, mostly women in religious orders. The 1990s saw the emergence of the title "intervenant(e)s en soins spirituels", a designation which is oriented more towards healthcare professions and which is still common today, although it has been joined by "accompagnant:e spirituel:le" in recent years.[99]

In parallel to the change in professional titles, there is also a change in the name of the organisation responsible for training: "the ini-

98 Sozialgericht Karlsruhe, Urteil S 9 KR 1621/17, 47.

99 Cherblanc/Jobin, L'intervention spirituelle dans les institutions sanitaires au Québec. For developments in British Columbia, see Reimer-Kirkham/Cochrane, Resistant, reluctant or responsible.

tial professional organization that trained and educated students in pastoral care and counselling was the Canadian Council for Supervised Education formed in 1965 […]. The Canadian name changed in 1974 to Canadian Association for Pastoral Education (CAPE). […] The name changed again in 1994 to Canadian Association for Pastoral Practice and Education (CAPPE). In 2010, the association changed its name to Canadian Association for Spiritual Care (CASC). […] The reason for the last name change was to reflect more of the multi-faith and multicultural dimensions both in Canadian society and in CASC. […] With the change of the name to CASC, the names of the clinical specialities also changed: Certified Practitioner of Spiritual Care (formerly Pastoral Care) and Certified Practitioner in Psycho-spiritual Therapy (formerly Pastoral Counselling)."[100]

Most remarkably, the degree of *Certified Practitioner of Spiritual Care* or *Certified Practitioner in Psycho-spiritual Therapy* is recognised by the official professional association for psychotherapy, with the consequence that graduates can practice independently. The change manifested in these professional titles was part of a wider reorientation in policy concerning religion, the turn towards "open secularism", a political concept developed in Quebec that can be seen as the epitome of a post-secular society. A government report published in 2007, written by sociologist Gérard Bouchard and philosopher Charles Taylor, explains the concept as follows: „open secularism, which recognizes the need for the State to be neutral (statutes and public institutions must not favour any religion or secular conception) but it also acknowledges the importance for some people of the spiritual dimension of existence and, consequently, the protection of freedom of conscience and religion."[101]

The Bouchard-Taylor report calls for a holistic approach to public health that takes into account the spiritual dimension.[102] To this end, the Ministry of Health[103] in 2010 transferred the responsibility for

100 Cf. O'Connor/Meakes, Three Emerging Spiritual Practices.

101 Bouchard/Taylor, Building the Future, 140.

102 Bouchard/Taylor, Building the Future, 169.

103 Ministère de la santé et des services sociaux du Québec, Orientations ministérielles pour l'organisation du service d'animation spirituelle en établissements de santé et de services sociaux 2010.

healthcare chaplaincy to health institutions themselves, which are now legally obliged to attend to the spiritual needs of their patients.[104] Since that time, the mandate of a faith community has no longer been required in order to work in healthcare chaplaincy in Quebec. It remains unclear in which direction healthcare chaplaincy will develop under these new conditions. In an article published in 2013, Jacques Cherblanc and Guy Jobin point to the tendency to conflate the spiritual dimension with the psychosocial and to psychologise chaplaincy tasks.[105] At the same time, there is a discernible effort on the part of chaplains to distinguish themselves as belonging to a distinct profession and to clarify the relationship of chaplaincy to social work and psychology.[106]

England and Scotland: Spiritual care within the remit of the state healthcare system (NHS) – two models

In the United Kingdom we find two diverging answers to spiritual diversity which are instructive for international developments. While England chose the path of a "re-housing' of religion"[107] within the framework of a multi-faith model, Scotland opted for "generic chaplains". These differences are all the more remarkable because they developed under the same framework conditions. The New Labour government, in power from 1997 to 2010, viewed religious communities as a social resource to be promoted and utilised for the common good. In 2003, after preliminary work by a *Multi-Faith Group for Healthcare Chaplaincy,* the Department of Health published guide-

104 Gouvernement du Québec, Loi sur les services de santé et les services sociaux, 2005, Art. 100.

105 Cherblanc/Jobin, L'intervention spirituelle dans les institutions sanitaires au Québec.

106 Cf. Bélanger et al., The Quebec model of recording Spiritual Care.

107 Swift, Hospital Chaplaincy in the Twenty-first Century, 5. According to Fraser, Charting the Journey towards Healthcare Professionalisation in the UK, 119, it was external factors (including the partial privatisation of the health system) that led to this development: "It is interesting to note that the people, pressures and circumstances which have catalysed such profound and positive change in the recent history and development of chaplaincy have largely been external (and unexpected and/or uninvited) ones."

lines for those responsible for "chaplaincy-spiritual care" under the programmatic title: *Meeting the religious and spiritual needs of patients and staff*. In the foreword, the Chief Nursing Officer, Sarah Mullally, explains the purpose of the guidelines: they are to "enable chaplaincy services to meet the needs of today's multi-cultural and spiritually diverse society".[108] For the purpose of diversity management, a distinction is made between spiritual and religious needs:

> "Spiritual needs may not always be expressed within a religious framework. It is important to be aware that all human beings are spiritual beings who have spiritual needs at different times of their lives. Although spiritual care is not necessarily religious care, religious care, at its best, should always be spiritual."[109]

This recognition of the spiritual dimension as an anthropological given was not, however, taken by the advocates of this health policy to favour a form of chaplaincy that operates independently of faith communities. Rather, the guidelines emphasise: "In order to respond in the most appropriate way to the distinctive religious needs of patients and staff, each member of the chaplaincy-spiritual care team retains the religious responsibility for his/her own faith community."[110] Along with the guidelines, the NHS published a 10-year development plan with numerous proposals, such as a fivefold grading of healthcare chaplaincy professional roles according to level of education.[111]

The implementation of these documents was complicated by the fact that the chaplaincy associations had not been included in their preparation. A further problem was the fact that the associations had a competitive relationship with one another. The disputes concerning these documents ultimately led NHS England to appoint Christopher Swift, an experienced and widely respected hospital chaplain, to revise the guidelines, which were published in 2015 under the title

108 NHS Chaplaincy, Meeting the religious and spiritual needs of patients and staff, 3.
109 Ibd. 5.
110 Ibd. 8.
111 NHS, Caring for the Spirit, Nr. 82.

Promoting Excellence in Pastoral, Spiritual & Religious Care. The term 'chaplain' is extended here to non-religious providers: "The term 'chaplain' is intended to also refer to non-religious pastoral and spiritual care providers who provide care to patients, family and staff."[112] The inclusivism prescribed by the 2006 Equality Act is also manifested in the understanding of 'religion' and 'belief': "(a) 'religion' means any religion, (b) 'belief' means any religious or philosophical belief, (c) a reference to religion includes a reference to lack of religion, and (d) a reference to belief includes a reference to lack of belief."[113] According to the guidelines, the composition of chaplaincy teams should correspond to the "user populations", which has led to the "growth of multi-faith teams" in larger organisations.[114]

The English multi-faith model follows the guiding principle: a diverse society requires a diversification of healthcare chaplaincy, whose composition must comply with the legal principle of equality. Paradoxically, this model is open to criticism precisely from the perspective of equality of opportunity. For even a multi-person chaplaincy team in a large hospital can at best only represent the largest faith communities in terms of personnel, never all of them. Since this model assumes clear faith identities and fixed denominational affiliations, it fails to represent not only smaller minority groups, but also all those whose religious and spiritual attitudes and affiliations are fluid. MacLaren summarises the criticism as follows:

> "[…] chaplains are predominantly badged according to a religious identity (Christian, Sikh, Muslim, and so forth), with the consequence that referrals are more likely to happen between patients and chaplains from similar religious backgrounds, with those not identifying as religious tending to receive disproportionately less spiritual care. […] the visibly religious presentation of the mul-

112 NHS, Promoting Excellence in Pastoral, Spiritual & Religious Care, 5.

113 Ibid. 6. The 2003 guidelines had used the following formulation: "For the purposes of this guidance, references to religion and/or faith are taken to include the nine major world faiths: Bahá'í, Buddhism, Christianity, Hinduism, Jainism, Judaism, Islam, Sikhism and Zoroastrianism" (NHS Chaplaincy, Meeting the religious and spiritual needs of patients and staff, 5).

114 Ibid. 14.

> ti-faith model arguably perpetuates the perception among clinical staff that chaplaincy teams are mostly there to provide religious care for the faithful".[115]

Since it is primarily people with strong religious identities, such as devout Christians, Muslims and Sikhs, who benefit from this model, it is not surprising that secularist groups (with the exception of the humanists, who see themselves as a denomination and strive to offer corresponding chaplaincy)[116] lobby for the abolition of state funding for chaplaincy.[117]

The dilemma of the multi-faith approach, which was already implicit in the 2003 guidelines, may have been an important reason why a different path was taken in Scotland. Anyone wishing to find out more about the Scottish approach can read the illustrated guidelines published by NHS Scotland in 2009 (and revised in 2021) with the programmatic title *Spiritual Care Matters.* In contrast to the 2015 NHS England guidelines, they have an interprofessional orientation, as illustrated in Figure 4.

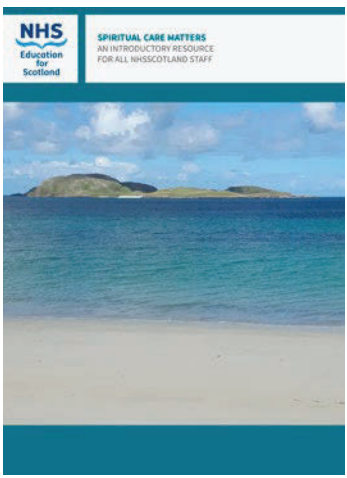

Fig. 3: Official Scottish guidelines on spiritual care (NHS Education for Scotland 2021). Noteworthy is not only the programmatic title, but also the chosen visual motif (photo by Morag Macritchie).

115 MacLaren, All Things to all People, 29.
116 Cf. https://humanists.uk/community/humanist-pastoral-support/
117 Cf. van Dijk, Humanist Chaplains.

Fig. 4: Illustration from "Spiritual Care Matters" (NHS Education for Scotland 2009, p. 9; drawn by Graham Joe Ogilvie). The guidelines emphasise the interprofessional nature of spiritual care.

From this interprofessional perspective, chaplains are understood as "specialist spiritual care staff"[118] – as health professionals, rather than as representatives of a faith community, as in England. Accordingly, the 2007 *Standards for NHS Scotland chaplaincy services* changed the description of a chaplain to the following:

> "A person who is appointed and recognised as part of the specialist spiritual care team within a health care setting. His or her job is to seek out and respond to those who are expressing spiritual and religious need by providing the appropriate care, or facilitating that care, through contacting, with the patient's permission, the representative of choice."[119]

118 Ibid. 9.

119 NHS Education for Scotland, Standards for NHS Scotland chaplaincy services, 2.

There is hardly any mention of religious diversity in the 2009 guidelines. The Scottish model does not see chaplaincy as denominational, but as generic. All chaplains working in NHS Scotland are equally responsible for all patients, relatives and staff, regardless of their personal background. The problem of ensuring adequate representation of different faith communities in the chaplaincy team is avoided in that there is no official representation of any community. In this way the model replicates the key modern distinction between public and private, and the privatisation of religion in the field of healthcare chaplaincy.

What appears to be an elegant solution, however, has a difficulty of its own: the disintegration of the healthcare chaplaincy mission and the spiritual character and competences of chaplains. This can be seen, for example, in fact that tasks that are judged, not unproblematically, to belong to (denominationally understood) "religious care" and not (non-denominational) "spiritual care" are increasingly delegated to external chaplains – which leads to strange situations in clinical practice. On the basis of his own chaplaincy work with NHS Scotland, Duncan MacLaren gives concrete examples of the problems this "uneasy compromise" can give rise to:

> "In this model, a chaplain who was by background an Anglican priest could be asked for Holy Communion by an Anglican patient, but would not be able to fulfil this request because he or she was not regarded as being there to provide religious care. Instead, they would be expected to call in the rector of the local Episcopal Church to provide this. In this example – drawn from real life – the manager who insisted on this was not being obstructive; he was simply being consistent with a widespread understanding of generic practice. Chaplains' religious identities are not deemed relevant for offering religious care. As one colleague put it, 'We are not paid to be priests.' Or, as another of my senior Scottish colleagues recently said when articulating this approach: 'When chaplains provide religious care, they step out of their roles as NHS chaplains and instead act as faith group representatives.'" [120]

120 MacLaren, All Things to all People, 30.

According to MacLaren, the artificial separation of spiritual and religious care does not merely endanger the integrity of the chaplains themselves: it is also impossible to uphold in practice:

> "If taken to its logical conclusion, however, the generic model starts to exhibit stress fractures. In practice, it is very unlikely that a Scottish chaplain, called to the bedside of a dying person in the small hours of the morning and asked to perform a blessing, would refuse and begin phoning round local faith group representatives for help. Scottish chaplains continue to perform baptisms, weddings, and funerals, to say blessings and pray prayers, to anoint the dying, and to create ritual moments for which they draw upon the resources of their training and formation. The idealized notion that chaplains can provide sanitized 'spiritual care' – free from 'religious' content – tends to collapse in the real world."[121]

MacLaren's suggestion that the generic model should be further developed and enriched with denomination-specific 'modalities' will be discussed below.[122] A third way along these lines, between the pluralisation of the denominational model of chaplaincy and a strictly generic chaplaincy, is also being sought in the Netherlands.

The Netherlands: Chaplaincy's "sanctuary function" as a public task

There is probably no country in which the financing of hospital chaplaincy is as clearly regulated as in the Netherlands. Inpatients in a health institution for longer than 24 hours have a fundamental right to publicly funded chaplaincy, "without control or approval by any third party".[123] In an allusion to the earlier practice of church asylum, this is called the "sanctuary function", which healthcare chaplaincy fulfils in a personalised way.[124] This legal framework has pro-

121 MacLaren, All Things to all People, 31.
122 Cf. chapter 7.
123 Zock, Chaplaincy in the Netherlands, 12.
124 Ibid.; ten Napel-Roos et al., Non-Denominational Spiritual Care Givers, 62.

vided for the dynamic development of chaplaincy in health care. The responsibility for the certification of suitable chaplains is assigned to the *Association of Spiritual Caregivers in the Netherlands (Vereniging van Geestelijk VerZorgers, VGVZ).* This intermediary institution is structured according to care setting (hospital, psychiatry, rehabilitation, nursing home, care for persons with disabilities, youth care and extramural care) on the one hand, and according to denominational affiliation on the other. At present, there is one section each for Protestant, Roman Catholic, Jewish, Humanist, Muslim, Hindu, Buddhist and non-denominational chaplains.

The difference between humanist and non-denominational chaplains is of considerable importance. The decline of ecclesiastical influence in the Netherlands led to the development of humanist chaplaincy earlier than in other European countries. To regulate it, an organization called Albert Camus was founded in 1995. The humanist chaplains expanded the denominational spectrum, but otherwise fit seamlessly into the structure of the VGVZ. Not so the non-denominational chaplains, who challenged the organization in two ways: either by claiming multiple religious affiliations[125] or no affiliation at all. Their inclusion in the VGVZ in 2015, following intense discussions, made further clarification of the professional identity of chaplains necessary. Until then, in addition to a recognised chaplaincy qualification, an endorsement from a religious or worldview organisation was necessary. The fact that chaplains were being employed in healthcare institutions without such a mandate was considered to be problematic by the steering committee of the VGVZ appointed to clarify the status of such chaplains: "Graduates of these [non-denominational] programmes start to work in healthcare, based on professionalism only, without being tested on their spiritual competence."[126]

To provide a substitute for a mandate from an existing faith community, a *Council of Institutionally Non-Commissioned Spiritual Caregivers* was established with the declared aim "to assess the spiritual competence of non-denominational spiritual care givers".[127] The VGVZ

125 Cf. Berghuijs, Multiple Religious Belonging in the Netherlands.
126 Ten Napel-Roos et al., Non-Denominational Spiritual Care Givers, 67.
127 Ibid. 68.

understand the term "spiritual competence" to imply two things: On the one hand, "hermeneutic competence" understood as the

> "ability to clarify questions of meaning, to shed light on beliefs and customs relevant to the context or the situation, and to provide spiritual [levensbeschouwelijke; zingeving] counselling. This competence includes the ability to detect, articulate and interpret meaning as it is contained in texts, images, practices, life narratives, traditions and new forms of spirituality – relating to existential and spiritual questions, sources of beliefs and ethics, modern society, religion and culture. The crucial ability is to detect and articulate emotions, unasked questions, and implicit assumptions." On the other hand, spiritual competence includes the "ability to help people discover and renew sources of spirituality and belief. This competence is based on a broad knowledge of such sources, and the ability to adapt and present them where necessary in rituals and symbolic ways of expression."[128]

It should be beyond question that healthcare chaplains require spiritual competence and that this must be assessed in the context of professional certification.[129] The VGVZ has done important groundwork in this regard. Nevertheless, it remains questionable to what extent such an assessment can adequately replace the endorsement of a faith community, which should certify that chaplains are anchored in lived spiritual practice, so that they can be "a bearer of one's own religious or worldview sources".[130] The dilemma that the inclusion of non-denominational chaplaincy poses to the VGVZ is significant for our discussion, because it raises questions about how Christian healthcare chaplaincy can combine professional expertise with spiritual practice, and how it can ensure the latter isn't lost amid the growing professionalization of spiritual care. I will return to these questions in the part three.

128 Ibid. 70.

129 Cf. Smeets, Professional competence and autonomy of general spiritual caregivers in the Netherlands.

130 Ibid. 72.

Summary

In the first part of this book, we have identified three ways in which the framework for healthcare chaplaincy work has changed in recent years:

- *firstly,* through the partial reintegration of the spiritual dimension into healthcare and the development of an interprofessional understanding of spiritual care;
- *secondly,* through the growing religious and spiritual diversity of society;
- *thirdly,* through political shifts that are best understood in terms of post-secularity.

While the first of these changes affects healthcare chaplaincy in particular, the other two concern all kinds of chaplaincy in public institutions. Chaplaincy has responded to spiritual and religious pluralisation in two ways: by expanding the denominational spectrum and by neutralising the denominational backgrounds of chaplains. Given the diversity of religious and non-religious 'faith communities' and multiple belongings, the first approach quickly comes up against its limitations. Meanwhile, the second approach undermines the integrity of chaplains. In the light of these issues, there are now many attempts to combine the best of the two approaches, at both an institutional and an individual level.

As a consequence of the transformations described in the first part of this book, healthcare chaplaincy is increasingly part of the organisational field of public healthcare and is understood in terms of an expanded conception of health. In view of this multi-layered change, Christian healthcare chaplaincy must address anew the question of its theological foundations. The second part of this book is devoted to this task.

II Theological Foundations: The Christian Call to Healing

Fig.: Sigmar Polke, Agate window at the entry of the Grossmünster, Zürich (© AdobeStock/juhanson)

The lighting of the interior of Zurich's Grossmünster has been reversed and sacralised by Sigmar Polke's windows.[131] They are translucent but without permitting a view of the outside world. Gaze at them, let them take effect and you will find yourself in a darkened room looking through the translucent glass windows towards a sphere of light that surrounds the interior as if with a permeable membrane: the clearly defined world is enveloped by an infinite space of light that penetrates the darkness through discrete openings, creating a space pregnant with hope. The path that opens up will lead you from twilight into light, from the inside to the outside. Gazing upward at the windows will gather and settle you, even if the windows might hint at disturbing things, stories of suffering and sacrifice. Such stories can be found even in the agate windows, as some of the stone sections selected by the artist recall the scanned cross-sections of human brains or microscopically enlarged bacterial cultures.

The Christian call to healing, which is the subject of this second part, is located in the space where experiences of suffering and encounters with a healing power come together. How and where is this healing mission carried out today? And in what way does healthcare chaplaincy act within the scope of this mission, which from a biblical perspective is tied to a form of empowerment?

Given the changes in global health and society highlighted in the first part of this book, it is necessary for us to reconceive the mission of healthcare chaplaincy. This will involve the question of the theological justification of chaplaincy in today's healthcare sector. Towards which guiding conception can church mandated healthcare chaplains orient themselves in healthcare institutions that are increasingly pluralistic, in both religious and ideological terms, and in which interprofessional cooperation is becoming ever more important?

The second part of this book answers this question by recalling the Christian call to healing. It is important that Christian healthcare chaplaincy is understood in the context of this calling. It is one of many institutional ways of answering this call in the contemporary world. Although it may be unusual to appeal to the Christian

131 See La Roche, Sehen und Hören, 76 f.

healing mission in this context, in ecumenical terms it is on firm ground: "Our vocation to health and healing is as strong as it has ever been," affirmed Olav Fykse Tveit, General Secretary of the WCC, with regard to the *Global Ecumenical Health Strategy 2018.*[132]

To reiterate what was explained more fully in the first chapter: Since the first Tübingen consultation on this topic (1964) and the founding of the *Christian Medical Commission* (1968), the health policy engagement of the WCC has been marked by a process of theological exploration in a post-colonial era. As early as 1964 it was said: "The church cannot surrender its responsibility in the field of healing to other agencies."[133] But in what does the Christian healing mission consist in today's healthcare sector? And how is the Christian call to healing substantiated in chaplaincy practice?

The following chapters treat these questions in several steps. To begin with, the third chapter elaborates on the nature of the Christian call to healing by reconstructing its biblical foundations. The fourth chapter discusses contrasting options for answering this call to healing under current conditions and considers the prospects for a Christian understanding of healing in view of contemporary models of health. Finally, the fifth chapter takes up the question raised here of what it means to understand healthcare chaplaincy within the context of the Christian call to healing. With a view to providing a theologically informed understanding of healing, it should be noted in advance that the division between care for the body and care for the soul, which remains influential to this day, must be overcome. The fact that good healthcare chaplaincy also involves the bodily dimension and has "good news for the body" to impart is not a new insight, to be sure.[134] However, the theological consequences for the self-understanding of healthcare chaplaincy need to be spelled out more precisely.

132 https://www.oikoumene.org/news/our-calling-to-health-and-healing-is-as-strong-as-ever https://www.oikoumene.org/en/press-centre/news/201cour-calling-to-health-and-healing-is-as-strong-as-ever201d (19/10/2023).

133 World Council of Churches, Witnessing to Christ today, 14.

134 See Henriksen/Sandnes, Jesus as Healer.

3 Biblical Foundations: Sent Out to Heal

According to the New Testament account, the mission with which Jesus entrusted his disciples includes not only spreading the gospel but also healing all kinds of sickness and affliction: "Then Jesus called the twelve together and gave them power and authority over all demons and to cure diseases, and he sent them out to proclaim the kingdom of God and to heal." (Lk 9,1–2)[135] The Christian call to healing is founded, both historically and theologically, in the ministry of Jesus himself. "Jesus was a healer and exorcist with a special profile that is still recognisable today."[136] The disciples are called to continue what distinguished Jesus' ministry: mediating God's healing presence. In the Lucan version just quoted, the narrative context highlights this connection: The mission to heal follows the healings of the woman suffering from haemorrhages and of Jairus' daughter.

This book anchors healthcare chaplaincy in this call to healing. In this way, specialised spiritual care is placed in the overall context of Christian engagement in healthcare. The biblical foundations for this will be developed in the following steps: First, I briefly outline four reasons why the call to healing has been marginalised and why it must be rediscovered; next, I sum up a number of exegetical insights into Jesus' healing mission; finally, I look at the narratives of Jesus' multifaceted healing ministry, guided by the assumption that they flesh out what the Christian call to healing means.

135 Later Jesus gives the mission to an extended group of Jesus' followers as well and sends them out (Lk 10,9).

136 Theißen, Symbolisches Heilen in der Nachfolge Jesu, 50.

Overcoming Interpretative Shortcomings

A contemporary exploration of the Christian call to healing has to deal with the legacy of four interpretative biases. The first one can already be seen in Matthew's Gospel.[137] Here, the specific mission to heal is subsumed into Christian charity in general. The pre-Easter mandate to heal segues into the post-Easter care for the sick, which is defined as one of several works of mercy (Mt 25:36). In the Great Commission, which concludes this gospel (Mt 28:19–20), there is no mention any more of healing. Matthew paves the way for later "interpretations which understand Jesus' call to healing in terms of charity".[138]

No less problematic is the spiritualization of the call to healing. The more people thought in the dichotomous scheme of body and soul and interpreted biblical texts allegorically, the more they understood the New Testament healing stories in a purely spiritual way.[139] Finally, the Fourth Lateran Council (1215) codified and emphasized the strict division between medical care (for the body) and spiritual care (for the soul). This professional division of responsibilities, as controversial as it was over the centuries, has remained influential to this day.

The third bias has become particularly pronounced in modern times: to narrow the interpretive focus to the miracle aspect.[140] Understood as a miraculous interruption of natural law causalities, the Christian healing mission comes into contrast and conflict with medicine. A sense that God's healing presence can be mediated through human healing practices is lost in this interpretive approach.

137 Popkes, Der Krankenheilungsauftrag Jesu, 125 f. (similarly, Luz, Matthew II, 94). Note, in particular, that even in the Didache, which in many respects ties in with Jesus' commissioning speech, there is no mention of the healing mission.

138 Popkes, Der Krankenheilungsauftrag Jesu, 145.

139 See the evidence collected in Nielsen, Heilung und Verkündigung, 246–252.

140 Henriksen/Sandnes, Jesus as Healer, 134: "To the extent that healing is a theme in contemporary systematic-theological discourse, it is most commonly seen as a part of the miracles, which have been debated since the Enlightenment. In much of this discussion, healing as such is therefore not the main topic, but rather the assumed miraculous character of the healings. This situation has led to a general de-emphasis of the theological significance of healing as such."

Finally, there is the bias of an exclusively historical interpretation of the biblical texts on healing. On such a reading, the New Testament narratives appear as more or less reliable testimonies about the therapeutic interventions of Jesus and his followers. One may then conclude, as Calvin did, that while healing contributed to the spread of Christianity in its early days, this function cannot be transferred to later times.

To overcome these interpretative shortcomings, I suggest that we read the New Testament healing narratives as testimonies aiming to evoke the transformative presence of God, which can be felt anew by those who hear these stories.[141] They testify not to a past, but to a present possibility. Seen in this light they are stories of hope that envision a presence that transforms human life in *all* its dimensions.

The Profile of the Christian Call to Healing

All three synoptic Gospels testify to the call to healing – and Luke does so twice (Mk 6:7–12; Mt 10:1, 7–11; Lk 9:1–6; 10:1–12). The differences between the accounts are no less instructive than the similarities. The narrative embedding in the pre-Easter mission of the disciples is common to the three gospels, as is the introductory remark that the disciples were given authority over demons. But it is already at this point that the first differences become apparent. In Matthew and the first commission in Luke, the power to cast out demons is placed in parallel with the granting of authority to heal the sick, whereas in the second commission in Luke, only the mandate to heal is mentioned. In Mark, on the other hand, the mission to heal seems to be included in the granting of authority over demons.

All the more remarkable is the summary in the earliest gospel: "They [the disciples] cast out many demons and anointed with oil many who were sick and cured them" (Mk 6:13). The reference to anointing with oil, which is only found in Mark's Gospel, is striking. It connects the therapeutic ministry of the disciples with practices that were com-

141 Such a hermeneutical approach is close to the intentions of narrative theologies, cf. Mauz, Theology and Narration; Zimmermann, Frühchristliche Wundererzählungen, 40.

mon in ancient medicine. At the same time, Mark also distinguishes the disciples' ministry from Jesus' healing ministry, which managed without pharmacological aids. This tendency towards normalisation conforms to the anti-enthusiastic direction of Mark's Gospel. It conveys to its readers "that, in dealing with the sick, the emphasis should not be on the expectation of miraculous healing, but on therapeutic care for those affected by illness".[142] In this way, drawing on established medical procedures is presented as a legitimate way of fulfilling Jesus' call to healing.

The evangelists disagree about the role of exorcism. While Mark emphasises the exorcistic element, Luke tones it down and integrates elements of rational medicine.[143] Descriptions of healing are easily distinguished from those of exorcism. In the latter "the focus is on the expulsion of a foreign power, in healing on the instillation of a power that is lacking. Exorcisms remove something, therapies replenish with vitality."[144] As a healer, Jesus often works through touch; as an exorcist, never. Here, the empowering word takes the place of the healing touch. But this difference poses fundamental theological questions: Is Jesus' call to healing based on the still widespread view that illnesses are caused by demons? Or does this difference reflect distinct therapeutic procedures and disease patterns (in modern terms, somatic and psychiatric)? The fact that no demons appear in most of the healing narratives supports the latter view.[145] The former is favoured by the foreshadowing of the entire therapeutic ministry of Jesus and his disciples by the "authority over spirits": the casting out of demons creates the space in which healing faith can form and healing can take place.

Two things should be noted in this regard: On the one hand, it is significant that Jesus' healing ministry and his call to healing are embedded in a worldview in which the influence of good and bad spirits was taken for granted. Insofar as the demonological language

142 Popkes, Der Krankenheilungsauftrag Jesu, 58.
143 Weissenrieder/Etzelmüller, Christentum und Medizin, 16.
144 Theißen, Wunder Jesu und urchristliche Wundergeschichten, 74.
145 Amundsen/Fengren, The Perception of Disease and Disease Causality in the New Testament.

refers to intermediate powers that put a strain on our relationship with God, it concerns the spiritual dimension of illness and health. On the other hand, it is equally significant for the Christian call to healing that Jesus' therapeutic work encompasses the whole spectrum of illness – physical disease and disability no less than psychological and social disorder. The inclusive formulation that Jesus went "curing every disease and every sickness among the people" (Mt 4:23) extends the Christian call to healing to its maximum. The therapeutic procedures reported in the Gospels are correspondingly broad.

This variety can even be seen in the semantic breadth of the terms used in the New Testament. The effect that Jesus has can be described in many different ways. Sometimes it is simply said that in Jesus' presence people become *healthy* (*hygiaino:* Mt 15:31; Lk 7:10, Jn 5:9 ff.). In other places it is said that the touch of Jesus (or touching him) is *saving* (*sozein;* Mk 5:28, 34; 6:54–56; 10:46–52). The healing work of the disciples is usually described with the verb *therapeuein.* Etymologically, this refers to "any service to people and deities"; only in the context of ancient medicine did it become a "*terminus technicus* for a healing activity".[146] The notion of service is thus already present in the therapeutic act: the charitable is included in the curative. *Therapeuein* refers to the whole spectrum of curative medicine, spiritual healing and care for the sick. In the parable of the Good Samaritan (Lk 10:30–35), which became central to the later interpretation of the Christian call to healing and combined it with an ethos of radical solidarity, the organisational and economical aspects of healthcare are present alongside medical care and nursing – the care is free of charge for the sufferer.[147]

In the Gospels, it is always people who are treated, not diseases.[148] The verb *iaomai,* which is common in Greek Medicine and which rarely occurs in the Gospels, appears all the more prominently in Paul's letters as the charisma of healing (1 Cor 12:9). It is remark-

146 Popkes, Der Krankenheilungsauftrag Jesu, 24.

147 Cf. Popkes, Der Krankenheilungsauftrag Jesu, 101: "These statements prove to be utterly revolutionary when read against the background of contemporary accounts describing the plight of the socially underprivileged sick in the Imperium Romanum."

148 Except in Lk 9:1.

able that it is distinguished from the charisma of miracles. Thus, curative medicine, if guided by the Spirit, may also find its place among the charisms.

The findings of the recent research literature can be summarised in eight points. *First,* in the New Testament texts, illness appears as a diminished state of being.[149] To be sick is to be weakened *(asthenes).* "Illness is […] described as the weakening of an originally good condition. This weakness can be attributed to various causes, e. g. to a disease, narrowly, […], but also more broadly to injuries and physical or mental disabilities."[150] Accordingly, recovery is an energetic process, a form of empowerment. People rediscover their vitality, a strength that can be understood as physical as well as mental or spiritual.

Second, the command to the disciples to heal belongs to the earliest traditions in New Testament literature; it can most probably be traced back to Jesus himself.[151] *Third,* it is not a secondary aspect of his ministry. The healing of all kinds of illness (Mt 4:23) lies at the heart of Jesus' ministry and his mediation of God's presence, which renews people in every dimension. *Fourth,* the mandate to heal is, accordingly, an essential aspect of the commission of the disciples, not only of the twelve, but of later and present-day followers from all nations (Lk 10:9). *Fifth,* in contrast to Jas 5:14 f., the mandate to heal is universal. The disciples are called to care for all, not only for like-minded people. *Sixth,* Jesus' call to healing encompasses distinct therapeutic approaches – in modern terms: curative, rehabilitative and palliative – which are related to different forms of suffering (somatic, mental, social and spiritual) and different situations.

Seventh, this therapeutic ministry is pneumatically (and eschatologically) enabled – as a gift empowered by the Spirit. The call to healing grows out of Jesus' therapeutic ministry, from his mediation of the presence of God. The healings of the sick show that "the king-

149 Cf. Pilch, Healing in the New Testament, 13, who writes with regard to the healing of the paralytic (Mk 2:1–11): "What a Western reader might interpret as a loss of function, namely lameness, an ancient reader would see as disvalued state of function."

150 Popkes, Der Krankenheilungsauftrag Jesu, 23.

151 Cf. Popkes, Der Krankenheilungsauftrag Jesu; Henriksen/Sandnes, Jesus as Healer, 11.

dom of God brings salvation for the *whole* person."[152] Jesus' healings reveal that in God's presence creation is made complete.[153] In this therapeutic ministry, as in the meal with sinners, proclamation and actualisation go hand in hand. And just as the disciples are to continue breaking bread together, so are they to carry on the therapeutic mediation of God's healing presence.

Finally, the call to healing is embedded in a radical Christian way of life. The empowerment to heal goes hand in hand with the mission to set out on their journey without any possessions, to let go of everything and to trust completely in God's providence (Mk 6:7–13; Mt 10:7–10; Lk 9:1–6).

A Matrix of the Christian Call to Healing: Healing Stories

Jesus' call to healing is to be interpreted – historically and theologically – in the context of the many reports that present him as a healer. From these healing stories, which appear in astonishing variety and abundance in the Gospels, we gain a tangible understanding of what the Christian call to healing means. Anyone who wants to understand and enact the Christian healing mission would therefore do well to study these narratives more closely.[154] What characterizes the healing practices depicted in these narratives? It must first be noted that Jesus does not heal for personal gain. The healings he performs are free of charge (Mt 10:8). The healing work that is made present in the narratives is accessible to all. Furthermore, the healings do not follow a fixed method. Although it is reported that he heals many, each healing story has its own character. This may be because the variety of different illnesses and diseases Jesus encounters do not allow for a uniform procedure. Jesus' therapeutic ministry has a spontaneous character, following a charismatic impulse, rather than

152 Schrage, Ethik des Neuen Testaments, 28, quoted in Popkes, Der Krankenheilungsauftrag Jesu, 14.

153 Nielsen, Heilung und Verkündigung, 262.

154 A comprehensive study can be found in Kollmann, Jesus und die Christen als Wundertäter.

a sapiential logic – as found, for example, in Ben Sira's praise for the wise physician (Sir 38:1–14).[155] Put another way: Jesus' healings are embedded in a relationship that unfolds in an unpredictable way.[156]

Despite the diversity of the healing narratives, certain common characteristics nevertheless emerge. Often, though not always, the healings happen through touch. As much as Jesus may resemble ancient healers, the fact that he works almost entirely without the usual aids sets him apart. Neither pharmacological substances nor fixed rituals are employed. In most of the stories, there is not even a healing prayer. Instead, it is the faith of the sufferers that is of central importance. If anything about Jesus' therapeutic ministry is historically unique, it may be the formula: "Your faith has made you well" (Lk 17:19). What may appear to be a modest gesture of a humble healer has a peculiar reversal effect: When the healed "attribute the healing power to the healer", Jesus instead "reattributes it – against their expectations – to their faith".[157]

There is no theological consensus as to how faith healing is to be understood. Interpretations go in two directions. The first is taken by Gerd Theißen, who understands healing faith as trust "that is grounded in the personal and charismatic relationship between the sufferer and the healer."[158] Jesus has discovered that the trust and belief of the sufferer play a decisive role in the therapeutic process. While Theißen thinks that faith spoken of in the New Testament healing stories is not of a Christological nature, others maintain precisely this. This results in a contrasting understanding of the crucial formula: The faith that heals is faith in God's presence as embodied in Jesus.

If the New Testament healing stories do indeed flesh out what the Christian call to healing means, then one particularly striking feature of these narratives is surely significant: the concentration of healing on the Sabbath. The evangelists do not give any reasons for

155 On this contrast: Jobin, Spirituality in the biomedical world.

156 Cf. Kostka, Der Mensch in Krankheit, 211: "The texts clearly emphasise the nature of illness, healing and rehabilitation as processes. This can be seen as suggesting a dynamic concept of illness and health."

157 Theißen, Symbolisches Heilen in der Nachfolge Jesu, 54.

158 Theißen, Symbolisches Heilen in der Nachfolge Jesu, 52 f.

this. So, what prompted Jesus to heal on the Sabbath as often as he did? The answer is likely to be found in the contemplative power of the Sabbath, the radicality of rest before God. The Sabbath is a sacrament of God's rest and renewal. An atmosphere of contemplative calm and peace offers particularly favourable conditions for the work of healing.

Paradoxically, the healings during the peaceful hours of the Sabbath caused great unrest.[159] If one supposes that the sufferings Jesus sought to heal were partly caused by rigid social and religious norms, it is not unreasonable to think that this taboo-breaking may have had a therapeutic aim: "Intolerant and rigid norms lead to psychological anxiety. Generosity in dealing with them provokes social conflicts, but also gives greater freedom."[160]

Summary

"Healing", as presented in the New Testament narratives, are complex events in which all life's dimensions are intertwined, dimensions which today are usually separated and assigned to different caring professions: physical, mental, social, spiritual. The New Testament healing stories are told from a variety of perspectives. The evangelists testify to the perspective of the disciples as (potential) healers as well as to that of those who have found healing in God's presence. For a deeper understanding of the Christian call to healing, both sides must be given equal weight: that of the healers and that of the healed. Since the former will be discussed in detail in later chapters, I will concentrate in the following chapter on the latter: on healing as it presents itself to those who receive it.

159 It is historically disputed whether such healing activity was actually understood as Sabbath-breaking by the religious authorities of the time. Collins, in his Jesus, the Sabbath and the Jewish debate, shows that Jesus' interpretation of the Sabbath commandment had the support of important rabbinical authorities.

160 Theißen, Symbolisches Heilen in der Nachfolge Jesu, 59.

4 The Christian Call to Healing in Contemporary Healthcare

How can the Christian call to healing be put into practice in a healthcare system characterised by global pandemics, the unequal distribution of resources and highly divergent conceptions of health and healing? With regard to the global South, it is not difficult to find an answer: Christian institutions and communities make a significant contribution to health care here.[161]

Case study:
Robert Vitillo's experience of the Kingdom of God in Uganda

During a workshop in Geneva held alongside the World Health Assembly in May 2005 and dedicated to the spiritual dimension of healthcare, Robert Vitillo, a Catholic priest and social worker then representing the Holy See at the WHO, recounted: "One of the most moving experiences in my life occurred when I accompanied Sr. Ursula Sharpe and her Mobile Home Care Team from Kitovu Hospital in Masaka, Uganda, to a rural village in the neighbouring Rakai District. After struggling to pass through much dust, roads in great disrepair, and the thick vegetation of banana plants, we stopped at the home of an old Muslim merchant. He offered us places of honour in his humble house. We exchanged pleasant greetings and asked about his family which consisted of several wives and children. Then he asked Sr. Ursula to examine and treat the purulent sores on his buttocks and to pray with him. During this curiously sacred moment, I experienced a great advance in my understanding of the mission of the Church and of human nature. At that moment, there was no more difference between the white Christian woman and the black Muslim man. In that hot and dirty house, we found our true and common identity – the identity of sons and daughters of

161 An overview can be found in Fleßa, Why do Christians care?

> the one Creator, sons and daughters who feel a deep relationship and a call to give praise to the merciful God who offers sufficient love to all God's children."[162]

For Vitillo, the widely travelled health diplomat and, for many years, head of *Caritas Internationalis,* one of the most moving experiences was of the utmost simplicity: an Irish nurse's treatment of a festering sore, where the Muslim patient is the host and invites the Catholic nun and the accompanying priest to join him in prayer. In this testimony of an encounter in a remote part of the world, as fleeting as it is lasting, various threads of Christian-inspired health commitment over the last century come together. The commitment that springs from the Christian call to healing transcends boundaries. It can be found at the margins.

This book is about current challenges for healthcare chaplaincy, of course, and there seem to be few points of contact between Christian healthcare engagement in the Global South and questions about the future of Christian healthcare chaplaincy in highly specialised and secular healthcare systems. But appearances are deceptive. Global health has long been more closely interlinked than is generally appreciated. This interlinking doesn't only follow the flow of global migration, which leads to chaplains in Western European hospitals attending the relatives of patients who are cared for by nuns like Sr. Ursula Sharpe in southern countries. It also runs in the other direction, as shown by the example of Richard Bauer quoted above. The next section will provide further clarification of the relationship between the Christian call to healing and secular healthcare. This will help sharpen the profile of the Christian call to healing and bring out its significance for the self-understanding of Christian healthcare chaplaincy.

162 Vitillo, Role of Faith in the Global Response to HIV and AIDS. Sr. Ursula Sharpe belongs to the community of the Medical Missionaries of Mary.

Three Basic Options

Again: How can the Christian call to healing be realized in today's healthcare system? At a conceptual level, there are three options to consider: Proponents of the *first option* understand the Christian call to healing as a task to be fulfilled mainly *outside of* the state-regulated health care system: through prayer, anointing, exorcism etc.[163] According to this counter-cultural[164] option, which can rightly appeal to Jesus' charismatic healing practice, the means and forms of Christian healing practice differ fundamentally from secular medicine, nursing and psychology. The theological problems of this approach are self-evident: By confining healing to certain religious practices and, as a result, restricting it to the congregation, this approach fails to uphold the universalism of Jesus' healing ministry and Christian healthcare, which takes Jesus himself and the parable of the Good Samaritan as its yardstick. At the same time, adherents of this approach risk closing themselves off from developments in modern healthcare and failing to recognise their share of responsibility for them.

In contrast, the *second option* emphasises the universalism of the Christian call to healing. The key motive here is to help humanise healthcare and to fight for justice and accessibility to contribute, inspired by Christian faith. According to this view, the Christian contribution does not consist in specific methods (as God also heals by means of modern medicine and psychology[165]), but in a particular motivation and approach. Understanding and practising one's health profession as a vocation does not mean distrusting evidence-based procedures, but rather, guided by a Christian ethos, using them to the best of one's knowledge and ability to benefit as many people as possible. Similarly, healthcare chaplaincy is better able to fulfil its mandate if it is prepared to avail itself of modern psychological

163 Cf. Brown, Global Pentecostal and Charismatic Healing.

164 Cf. Balboni, A Theological Assessment of Spiritual Assessments. In this piece, Balboni distinguishes three theological approaches that coincide on many points with the options outlined here.

165 In the Gospel of Luke, the Christian healing mission is, to a certain extent, accommodated to the means of ancient medicine. The most apposite biblical text for this option, however, is the Book of Sirach 38.

knowledge and skills. This second option undoubtedly opens far more possibilities for answering the Christian call to healing. But is there nothing more to the Christian call to healing than the demanding and unending task of implementing medical procedures and psychotherapeutic approaches *in a Christian spirit?*[166]

The *third option* seeks to go a step further at this point by highlighting the life-changing character of spiritual experiences, of the presence of God's spirit. This option corresponds to an approach described by Miroslav Volf as "internal difference". It involves an attempt at "living Christian difference within a given culture: the majority of the elements of a culture will be taken up but transformed from within".[167] On this approach, the Christian call to healing is primarily met in taking shared responsibility for good and just healthcare provision by using *and transforming* all available methods. The goal is to (trans-)form secular healthcare "from within" through Christian involvement in its design. Even though the WCC and the Catholic Church agree on this option, it is unclear what it would mean for the future development of Christian healthcare chaplaincy. With a view to this question, the following sections attempt to spell out the third option further.[168]

Medical Goals and the "Christian Difference"

In order to clarify the relationship between the Christian call to healing and secular healthcare, and to avoid unfair comparisons, it is necessary to start out with a nuanced understanding of medical objectives that is capable of achieving broad acceptance. If there is one document that fits this description, it is the New York *Hastings Center Report* on the *Goals of Medicine,* published in 1996. Fourteen groups of countries were involved in this consensus-building project, which was led by the renowned medical ethicist Daniel Callahan.

166 Guy Jobin's critique of the medicalization of spirituality can be understood as expressing reservations about this second option, cf. Jobin, Spirituality in the biomedical world.

167 Volf, A Public Faith, 91.

168 An attempt to strengthen this option, albeit with a different emphasis, can be found in Michael and Tracy Balboni, Hostility to Hospitality.

The *Hastings Center Report* offers a robust and nuanced foundation for the clarification sought here. In a critical analysis of modern medicine, the report highlights the one-sidedness and limitations of contemporary healthcare and concludes that a reformulation of the current goals of medicine is necessary for economic, socio-political and clinical reasons. To this end, the report sets out four main goals of equal importance:

1. *The prevention of disease and injury and the promotion and maintenance of health.* It is an ancient goal of medicine "to help people live more harmoniously with their environment, an aim that must be pursued from the beginning of life to its very end".[169]
2. *The relief of pain and suffering caused by maladies.* The report distinguishes physical pain from mental suffering and calls for more attention to be paid to the latter.
3. *The care and cure of those with a malady and the care of those who cannot be cured.* The distinctions introduced in this context are significant for our discussion: "The healing function of medicine encompasses both curing and caring, and healing may in a broader sense be possible even in those cases where medicine cannot cure. It can heal by helping a person cope effectively with permanent maladies." (12)
4. *The avoidance of premature death and the pursuit of a peaceful death.* As with the second goal, the report emphasises the importance of palliative care and the responsibility doctors share for "humane care of the dying" (13) and mentions that no consensus could be reached on the issues of euthanasia and assisted suicide.

   Various possibilities for improvement are set out in connection with these four goals. It is not possible or necessary to deal with them in detail here. It is worth mentioning, however, that the overemphasis on curative medicine criticised in the first part of the report is clearly rectified in the four goals. Thus, *cure* does not appear as an independent goal, but in connection with the *care* of people with curable and incurable diseases. It is also emphasised here that there is a form of *healing* that lies outside the realm of curative medicine.

169 Callahan, The Goals of medicine, 10.

The *Hastings Center Report* offers a solid foundation for specifying the relationship between secular healthcare and the Christian call to healing. Where and how could the "Christian difference" be inscribed in the four goals of medicine? Consider the following three options:

5. *In the way care is provided and medical goals are pursued:* The "Christian difference" concerns, first of all, the manner – or the spirit – in which people work towards the stated goals. Our basic attitudes and beliefs shapes how we do things. When clinicians conduct their work in the confidence that God's presence plays a role in recovery and healing, this will have an impact on therapeutic processes.
6. *In a spiritual attitude towards patients:* From the perspective of Christian faith, patients are far more than recipients of help and care. In caring for them, we reveal what is promised to all: that a treasure is hidden in fragile vessels.
7. *In a Christian refinement of therapeutic procedures:* The Christian difference can also be realized in the implementation of the goals of medicine. One example of this is the modern hospice movement, which has contributed to a profound change in the way we deal with dying and death. Another example is the attempts made by the WCC to reformulate the Christian understanding of health in line with the WHO definition. Clarifying the distinction between different forms of healing (cure/healing) can be an expression of Christian difference. The next section will explore this in more detail.

Cure and Healing

In order to contrast the different forms and dimensions of therapeutic processes, the *Hastings Center Report* distinguishes between *cure* and *healing*.[170] While the former is focused upon the restitution of organic functioning, the latter deals rather with transformative processes of unique persons (something that one might call "healing at a deeper or

170 Cf. Balducci/Modditt, Cure and healing; Cassell, *The Healer's Art.*

spiritual level"). In this usage, the two terms are to be understood as complementary: a curative recovery can be accompanied with healing, but the one is not necessarily associated with the other.

The distinction between *cure* and *healing* can be specified theologically. The US theologian, physician and medical ethicist Daniel Sulmasy has proposed a relational understanding of healing.[171] In the midst of physical and mental illness, healing takes place when impaired relationships are restored, when we find ourselves in a deeper communion with other people, with oneself, with God. Similarly, the concept of health can be understood relationally – as in the following case report.

Adam: "The healthiest person I know"

The paradox of healing in the throes of serious illness is described by Anglican theologian Brian Brock in a tribute to his son Adam – a name imbued with meaning.[172] He reflects that Adam, despite suffering from various difficulties and disabilities since birth, is the healthiest person he knows. Since, unlike himself, his son lives entirely in the present and has an unusually intense and affirming connection with his fellow human beings and his environment – and with God. Brock reminds us that healing is always embedded in relationships and draws on pre-reflective and imaginative resources that are developed in early childhood and can be nurtured even in cases of severe cognitive impairment.

What at first appears to be an exception, proves to be an acute form of the normal case: the co-existence of pathogenic and salutogenic processes. Human life is multi-dimensional and highly complex, which can lead to paradoxical simultaneities. Severely physically ill or impaired people may, of course, be mentally very alert and report spiritual wellbeing. The spiritual dimension in the context of illness

171 Sulmasy, The Rebirth of the Clinic, 125. For a relational understanding of healing, see also Swinton/Kelly, Contextual Issues, 181.

172 Brock, Health in a Fallen World.

and healing is related to the ability to distance oneself from one's own physical afflictions and mental distress.

Paul Tillich grounds the unity of the various forms of cure and healing in the multi-dimensional unity of life: "No individual can exercise all the ways of healing with authority, although more than one way may be used by some individuals. But even if there is a union of different functions, for example, of the priestly and medical functions in one man, the functions must be distinguished and neither confused with the other, nor may one be eliminated by the other. Healing is fragmentary in all its forms."[173]

Tillich distinguishes two possible biases in the relationship between the medical and religious forms of cure/healing: on the one hand, the attempt to replace medical methods with spiritual healing practices, and on the other hand, the hegemony of medical procedures:[174] "The healing impact of the Spiritual Presence does not replace the ways of healing under the different dimensions of life. And, conversely, these ways of healing cannot replace the healing impact of the Spiritual Presence."[175] The critical tenor of this statement is evident in Tillich's diagnosis that the psychotherapy of his day (i. e. psychoanalysis in particular) "often tries to eliminate both medical healing and the healing function of the Spiritual Presence".[176]

The identification of this problem is particularly significant in the present context. If chaplaincy is also meant to be therapeutic, how can this be justified and explicated? And how does chaplaincy relate to psychotherapeutic goals and methods? These questions have occupied the CPE since its beginnings. They can only be answered within the framework of a comprehensive theology of healing.

173 Tillich, Systematic Theology, 281 f.

174 The 1977 Consensus Statement on the Christian Ministry of Healing also warns against a spiritualisation of organic and mental illness, cf. Lucas, Christian Healing.

175 Tillich, Systematic Theology, 280.

176 Tillich, Systematic Theology, 281.

Starting Points for a Theology of Health and Healing

Healthcare chaplains often operate in different institutional zones, which are determined by diverse, often widely divergent ideas of healing. The sort of healing patients and their relatives hope for may differ significantly from the conceptions and expectations of the health professionals responsible for them. But even among health professionals, there is a wide variety of (official and personal) therapeutic approaches and ideas. And it is no secret that the same is true of chaplains. Discussions about the therapeutic laying on of hands or healing prayers, for example, show how disparate conceptions in chaplaincy circles are.

In view of this diversity, we need a theology of healing that takes the available empirical knowledge of therapeutic processes just as seriously as spiritual conceptions and experiences of healing. I shall approach this task in several steps: First, I present the state of ecumenical discussion as reflected in the documents of the WCC. Then I turn to *experiences* of healing and ask what theological insights can be drawn from them. In a final, synthesising step, I shall attempt to provide an understanding of healing as both *event* and *practice*. In view of the previous considerations, it should be noted:

- Therapeutic work is not limited to curative practices, but also includes palliative care, rehabilitation and preventative healthcare;
- Most therapeutic processes involve many people: besides the patient and the professionals, volunteers and the social environment also play a role – healing is always a systemic process;
- Finally, God's healing presence is *mediated through these activities as well as through mindful presence* without being exhausted by them.

The World Council of Churches' Ecumenical Consensus Documents

We have already touched upon the post-colonial background that has influenced the WCC's engagement in global health since the 1960s. In order to answer the Christian call to healing in changed circumstances, the WCC established the *Christian Medical Commission,* mentioned above, in 1968, which in the 1970s entered into

close dealings with the WHO. In this way, the WCC came to embody institutionally what it sought to promote: the Christian contribution to good and just global healthcare.[177] Through its close cooperation with the WHO, the CMC made an important contribution to the development of a new health policy paradigm, which was ultimately taken up at the highest health policy level at the momentous Alma-Ata Conference in 1978. In his foreword to the book *Health Promotion Churches,* published in 2020, the current WHO Director-General, Ethiopian Christian Tedros Adhanom Ghebreyesus, commends the partnership with the WCC as innovative and as setting an example for future collaborations: "The World Health Organization fully supports the WCC in this endeavour of promoting health and preventing disease through churches around the world, as well as in the vital role they play not only in spiritual healing but in ensuring health and wellbeing for all people."[178] And the WCC also played an important role in the development of the WHO guidelines on religious issues during the COVID-19 pandemic.[179] With this in mind, it is no coincidence that the WCC was guided by the WHO preamble when it formulated its definition of health. Here it is again:

> Health is a "dynamic state of well-being of the individual and society; of physical, mental, spiritual, economic, political and social well-being; of being in harmony with each other, with the material environment, and with God".[180]

Similar to the World Health Assembly a few years earlier, the WCC supplemented the biopsychosocial model of health with a spiritual dimension, understood in Christian terms as involving a relationship with God. It also emphasises the social and political determinants of health, which are defined positively, as in the WHO pream-

177 On the CMC, see Bersagel Braley, The Christian Medical Commission and the World Health Organization.

178 Makoka, Health Promotion Churches, xii.

179 WHO, Practical considerations and recommendations.

180 This definition is included in the document to which the numbers in the main text refer: WCC, The Search of a Christian Understanding of Health, Healing and Wholeness, 17.

ble: not as the absence of disease, but as a state of multidimensional well-being, thus giving greater weight to the subjective state of mind than to objective findings. This also results in a salutogenetic orientation. It makes the promotion of health central and is not limited to combating disease.

This understanding of health is further developed in the 2005 document *The Healing Mission of the Church,* written for the World Mission Conference in Athens, on which I shall focus here:

> "Such a holistic view underlines that health is not a static concept in which clear distinction lines are drawn between those who are healthy and those who are not. Every human being is constantly moving between different degrees of staying healthy and of struggling with infections and diseases." (No. 30)

The document understands health in terms of a multi-dimensional continuum model, according to which we are "never exclusively healthy or exclusively sick"; accordingly, health is to be understood as a dynamic equilibrium, a state of balance that must be continually reestablished.[181] The consequences that the WCC document draws for the Christian call to healing are of the greatest importance for this book:

> "The Christian ministry of healing includes both the practice of medicine (addressing both physical and mental health) as well as caring and counselling disciplines and spiritual practices. Repentance, prayer and/or laying on of hands, divine healing, rituals involving touch and tenderness, forgiveness and the sharing of the eucharist can have important and at times even dramatic effects in the physical as well as social realm of human beings. All the different means are part of God's work in creation and presence in the church. Contemporary scientific medicine as well as other medical approaches make use of what is available in the world

181 Franke, Modelle von Gesundheit und Krankheit, 17. Franke points out that genetic research, in particular, is blurring the boundaries between health and disease.

> God has created. Healing through 'medical means' is not to be thought of as inferior (or even unnecessary) to healing through other or by 'spiritual' means." (No. 30)

The World Mission Conference, for which this document was written, took place in the context of a debate with the Pentecostal-charismatic understanding of healing, to which some sections explicitly refer. Resisting a narrowing of the Christian healing mission to "spiritual means", the document emphasises that it also includes "medical means". What is to be promoted and to what extent will depend on the cultural and health policy context:

> "There are churches and social contexts (particularly in western post-Enlightenment and modern societies) in which a one-sided emphasis and attention was given to the achievements of contemporary scientific medicine and the physical aspects of health and healing. Here a new openness and attention is needed for the spiritual dimensions in the Christian ministries of healing. There are other contexts and churches in which – due to a different world view and the non-availability of modern western medical systems – the importance of spiritual healing is highly valued. Here also a new dialogue between spiritual healing practices and approaches in modern medicine is essential." (No. 31)

It is to the WCC's credit that it is resolute in bringing the perspectives of Southern countries into Western health discussions. In this way they make it clear that the globalisation of healthcare is not to be identified with the worldwide spread of Western biomedicine. In *The Healing Mission of the Church,* scientific medicine and spiritual healing practices are placed in a complementary relationship: The Christian call to healing can incorporate both. Respecting indigenous conceptions of healing, moreover, is an important part of overcoming medical colonialism:

> "The way health and healing are defined, sickness and illness explained, depends largely on culture and conventions. […] It is in particular the combination of religion, worldview and values that

> impacts people's specific understanding of and approach to healing. Since culture varies from continent to continent and from country to country or even within countries and groups of people, there is no immediate universal common understanding of the main causes of sickness and illness or of any evil affecting humans. […] Masses of people integrate popular religious beliefs and culture in their understanding of health and healing. We may call this popular religiosity and belief in health. This belief may involve veneration of saints, pilgrimages to shrines, and use of religious symbols such as oil and amulets to protect people from evil spirits or evil intentions that harm people. […] Out of different worldviews culture-specific medical sciences and systems developed in some of the major civilisations of the world. In particular since the Enlightenment, these were disregarded by the Western medical establishment, but are now again increasingly considered worthy alternatives for the treatment of specific illnesses." (No. 15–20)

The document is not content merely to demand and establish a new openness towards holistic healing practices. It goes further in presenting the Christian call to healing as a critical corrective to the idolisation of physical health:

> "In affirming that God himself in the life of his Son has lived through experiences of weakness unto even experiencing death himself, Christianity revolutionized the understanding of God and profoundly transformed the basic attitudes of the faith community to the sick, the aged and the dying. It contributed decisively to break up the conventional strategies and mechanisms of exclusion, of discrimination and of religious stigmatization of the sick and the fragile. It put an end to the association of the divine with ideals of a perfect, sane, beautiful, and un-passionate existence." (No. 25)

The WCC document outlines an ecumenical understanding of the Christian call to healing. Like the *Hastings Center Report* cited above, it approaches the question of healing primarily from the perspective of therapeutic actors: as a process facilitated by therapeutic activities. For a theology of healing, this perspective requires supplemen-

tation. For healing is not only an activity, but also a gift that should be understood from the perspective of the afflicted. I shall attempt to achieve this change of perspective in the following sections.

Experiences of Multi-Layered Healing

How can it be that body-soul dualism[182] remains so ingrained in contemporary health care, despite consistent criticism? The answer could lie in its reassuring capacity to simplify complexity: It offers a comprehensible and, therefore, reassuring order. Moreover, this duality also corresponds to a centuries-old division of professional roles, albeit one that is continually contested. Dietrich Stollberg remarked in 1972:

> "Where the psychosomatic approach to the understanding of illness is rejected, one side must consider the other to be irrelevant: either the doctors, the chaplains; or vice versa. If the chaplain is nevertheless 'tolerated' by the physician, because professional identities are negotiated according to the motto 'Ours, the body; yours, the soul,' then it can only be a matter of an unrealistic – and moreover unbiblical – dualistic anthropology, or else a failure to take the chaplain's mandate seriously: 'They may not be of much use, but nor do they do any harm; the patients should have all the comfort they need, like passengers on a cruise have their ship's chaplain.'"[183]

Move away from a dualistic anthropology does not mean forgoing all differentiation. Since healing processes involve all the dimensions of being human simultaneously and in a complex way, healing expe-

182 This is often traced back to Plato, although Platonic thought is itself more complex and indeterminate than is often appreciated. Waldenfels, Responsive Therapie im Zeichen der Sorge, 290 f.: "In Gorgias (464a-b), Plato distinguishes between the well-being of the soul and that of the body. The care *(therapeia)* of the body is in turn divided into *gymnastics,* which ensures correct order through physical exercise, and *iatrie,* which restores physical order through healing. This order has a cosmo-theological basis, as presented in detail in the Timaeus. The cohesion of soul and body is ensured by belonging to a cosmos which, as a living being on a large scale, itself has a world soul and a world body and is entirely in God's care."

183 Stollberg, Mein Auftrag, 35.

riences are themselves exceptionally diverse and multi-layered. The complexity and variety emerge most clearly when one moves from abstract considerations to the level of experience. Differentiation matters here: Just as the severity of an illness admits of gradations, so not every healing experience has the same existential depth. We can recover from serious illness without this becoming an existentially "deep" healing experience for us. And profound healing experiences do not occur only in response to life-threatening strokes. The story of the cleansing of the ten lepers, only one of whom returns to Jesus (Lk 17:11–19), points toward the possibility of recovery without healing. Some do not understand what they have received.

Experiences of being ill are always shaped by highly subjective ideas about illness and causality, and sometimes these ideas also have an impact on the progression of the illness. The same is true with experiences of healing: They are always shaped – and sometimes empowered – by implicit ideas, interpretations, and visions. Finding a new perspective on one's own situation can be key to the healing process. In biblical terms: God's presence opens up a new horizon of perception and interpretation, in which one can see more easily the blessing of one's life and embrace it.

Healing as an Event and as a Practice of Hope

To relate healing experiences to healthcare chaplaincy, I shall draw on the socio-anthropological studies of Cheryl Mattingly. In her seminal study of healing in the context of clinical occupational therapy, Mattingly started from the premise that lifeworld experiences are suffused with narrative and imaginative meaning.[184] Since healing processes themselves are structured (pre-)narratively, the narrative form is particularly well suited to articulating and facilitating healing processes. Patients and therapists do not just tell each other stories: they also follow scripts in their actions and may contribute to the emergence of a new narrative.

As Mattingly observes, the loss of possibilities through accident or chronic illness leads not least to narrative loss: to a storyline

184 Mattingly, Healing dramas and clinical plots.

being cut short. Working in the transitional worlds of clinics, occupational therapists have the task of preparing patients for an often radically changed everyday life. How can one's life story continue with a permanently disabled body? Since the therapy goal, which in this context is not curative but rehabilitative and palliative in nature, relates to personal values and is dependent on new priorities in life, it must be worked out by therapists and patients together and continually reviewed. According to Mattingly, storytelling is key to this process. Embedded in therapeutic interactions, it enables patients to reframe matters, to imaginatively sound out their limitations *as well as* their new life possibilities, which can be tried out in a safe therapeutic setting.

In a follow-up study, dedicated to chronically ill children of Afro-American heritage, Mattingly expands her focus to include culturally determined narratives and considers their significance for stories and experiences of healing. The stories of hope she examines provide alternatives which contend with biomedical narratives of cure. At the margins of a world defined by therapeutic success stories, the in-between realm of daydreaming hope and subcultural narrative is explored. Mattingly describes how families affected by illness and poverty cultivate empowering imaginative and narrative practices to nurture hope despite poor diagnoses. These everyday stories of healing are nourished by moments of significance in which the narrative texture of everyday events is condensed. They live off unexpected turnarounds in which hope can be reconfigured.[185]

Mattingly's concept of "healing dramas", validated in micro-analyses, which calls attention to easily overlooked and, in this sense, "undramatic" healing processes, is doubly significant for our reflections on the Christian call to healing: On the one hand, it offers an interpretative approach to the New Testament healing narratives, which tell of events in "borderland communities";[186] on the other hand, it helps us specify the Christian call to healing by providing an interpretative lens. The healing processes that are brought to the fore in this way sometimes have a paradoxical trait. Like the testi-

185 Mattingly, The Paradox of Hope, 144.
186 Mattingly, The Paradox of Hope, 216.

mony of Brian Brock quoted above, they point to an intensification of life amid and despite progressive illness and the nearness death. Although it is important to distinguish the different forms of healing from each other, it would be inappropriate to play "healing" off against "cure". Even in cases where all therapeutic efforts are unsuccessful, the struggle for cure and rehabilitation can provide a space in which people experience emotional and spiritual healing.

As the restoration or reshaping of broken or damaged relationships, healing has the character of a new beginning – and not merely of a single aspect of life, but of life as a whole. Whether this is perceived as the resumption of a lost thread of life or rather as the beginning of a new story is a question of perspective, which itself can change over the course of a healing process. The wonder that is a feature of the New Testament healing stories reflects the perception that a new reality is breaking through and changing the entire situation. The minor and major experiences of healing announce a future that is unfolding. In their limited and provisional nature, concrete healing experiences point towards a comprehensive and final healing. They nourish a hope that reaches beyond medical and curative objectives. In this respect, every healing event is a sign of the coming of what in biblical language is called *shalom*.[187]

Even if all attempts to provide curative healing fail and the focus moves to the best possible palliative care, healing can still be found. Key to this, according to Mattingly, is favourable interaction between the patients, their relatives and the professionals that together form transitional "borderland communities". In her socio-anthropological studies, she shows how fragile this interaction often is, how, precisely when end-of-life decisions must be made, conflicts break out and opposing views collide. This can also be seen in the following case report from the Department of Paediatrics at the University Hospital in Tübingen.

187 World Council of Churches, Witnessing to Christ today, 9.

Case study: Ursel's pain

Ursel was a 9-year-old girl with a neuroblastoma. She had developed this malignancy once before as an infant, when it had been treated with success. Her parents were active members of a free church and Christian faith had a central place in the everyday life of the family. Thus, they reported to the attending physician, the haematologist and paediatrician Dietrich Niethammer, that they had said to Ursel that she had been given to them by God twice: once at birth and once when she survived the first malignancy. Now, they were confident that he would do it again.

> "The treatment proceeded without a problem. The alert and always cheerful Ursel was a joy for all who came into contact with her. However, sometime after the end of the treatment there was a relapse that required further treatment. She was still the cheerful child that we all knew. The new treatment seemed to be successful at first. It took some time, but then new tumour growth appeared. It was clear that all curative possibilities had been exhausted. Ursel had asked us at the end of the last treatment what would happen if the tumour returned. We had informed her candidly that, in that case, we wouldn't be able to do anything to save her life. Now, she signalled clearly that she knew that she was going to die, and was able to speak about this very frankly. The parents spoke frankly about this too and their faith seemed to help them all to cope with the situation.

One day, the parents brought Ursel [...] to the clinic in unbearable pain. In fact, she was screaming because of these pains – although we couldn't find any organic cause for them. Nevertheless, high doses of morphine were necessary, with the result that she fell asleep. As soon as she awoke she started to scream again from the pain. It was exasperating for us all. Then, I spoke once again with the parents and asked them if anything significant had happened. The parents could not think of anything, although the father added that he had spoken with Ursel before the pains started and explained that it is the will of God that she has to die and that it has to be accepted.

> Although the father stated this calmly, I became bewildered. How could it be that a loving father, such as he, could accept the death of his daughter with such indifference? So, I asked if he had told his daughter how terrible her death was for him. That would be impossible, was his calm reply, as she might then lose her faith. I couldn't understand this, and a dispute followed, ending with him departing abruptly and slamming the door. His wife followed him with an embarrassed smile. Afterwards they took their daughter home without further discussion. Obviously, we were no longer suitable company for their daughter."[188]

The attending physician dared to question the father's stance, which was rooted in strongly held religious views. And he did so not only with the authority of an experienced paediatrician, but also, as will be seen shortly, inspired by his own religious convictions. The "borderland community", which had supported the family for years, has broken down when it is most urgently needed. The already very difficult situation is further exacerbated by this breakdown in communication. Ursel is now caught in a conflict between paternal and medical authority. This conflict continues at home and intensifies, only to resolve itself in an unexpected way. The doctor learns about it a few days later:

> "After a week or so, the mother came with Ursel to the consultation. The child was without any pain and was as cheerful as she had been before. I asked the mother what had happened in the meantime. She answered that I would certainly remember the father's anger at the end of our last conversation. After they had driven home father and daughter collided in the bathroom. All of a sudden, Ursel shouted at her father, reproaching him for his indifference about her death. Then he started to cry, embraced her and told her that it was the most horrible thing that could happen to him. And then the pains disappeared."[189]

188 Niethammer, Gut versorgt im Kinderkrankenhausbetrieb?, 24 f.
189 Niethammer, Gut versorgt im Kinderkrankenhausbetrieb?, 25.

The healing to which this case report bears witness is multifaceted. It did not deal with the tumour itself, from which Ursel died a short time later, but it nevertheless addressed a central aspect of her suffering. That the intense and uncontrollable pains should disappear so suddenly is, in the context of what Cicely Saunders described as *total pain,*[190] perfectly understandable. We can surmise that it is the articulation of her distress, the tears of the petrified father that free Ursel from her pain, that let her find her way back to the trust in life and God that carries her through illness and death. Or to put it more poetically: In the very moment that her cry finds resonance in her father's heart, her distress finds its release. What heals her pain is the palliative power of *compassio.*[191]

A healing entirely without medical support? Not quite: for the doctor helped make this catharsis possible. With regard to the Christian call to healing, it is worth dwelling for a moment on his spontaneous and unconventional intervention. Spiritual care is often associated with non-directivity. In the present vignette the physician chooses a different path. There is no question about the father's feelings: he obviously loves his daughter and cares for her. The physician builds on what he perceives and encourages the father to express his love to Ursel. In his spiritual care for the patient, the doctor does not shy away from addressing delicate issues. The father's statement, that his daughter's looming death is God's manifest will and must be accepted, is not ignored as being medically irrelevant, but is actively seized upon. What led the doctor to question this religious interpretation? Was it contrary to his own faith? Dietrich Niethammer wrote to me:

> "I probably made it clear that I do not believe that God acts so deliberately in individual cases. As it happens, this a point that has often led parents to ask me about my faith. I suppose I have always said that I am still struggling with my faith and have not received a clear answer. However, I have also said on occasion that if the parents believe the Lord is responsible for their child's death,

190 Saunders, Spiritual Pain.

191 Peng-Keller, Leiden, Schmerz und Compassion im Horizont von Spiritual Care. Bioethica forum 11:1 (2018), 11–13.

> they are surely allowed to be angry with God. A 10-year-old girl who knew she had to die once said to me: 'Professor, when I get up there (and she pointed up with her finger), I'll tell him how mean it is that he lets us children die!' I said she must certainly remember to do so, since I think it's mean too."

Niethammer thus deemed it appropriate in certain circumstances to disclose his own searching faith. This he did in two ways: as a form of encouragement and as an enquiry. He affirms the religious statement of the 10-year-old girl, while he questions the idea that God deliberately causes the death of a child.

The case report, which certainly does not provide us with a best practice model, raises questions that are key to answering the Christian call to healing in the health professions: How transparent – if at all – should Christian health professionals be about their own religious beliefs and attitudes in their conversations with patients? Under what circumstances, and in what form, is it permissible for them to talk about their faith? In a 2007 article, the US bioethicist Mark Kuczewski discusses these questions.[192] He focuses on doctors, but his discussion is relevant to all the professionals involved. At least two reasons can be given for not disclosing one's convictions: It can be argued that health professionals are not normally trained in religious and spiritual communication; and there is also the danger of hurting vulnerable people in an asymmetrical communicative context.

Kuczewski gives two main reasons why, in his view, it may be appropriate or even, in certain situations, crucial to show one's colours. First, for ethical reasons, health professionals should be willing to declare their guiding values and allow patients the opportunity to form a judgement about possible bias. Second, self-disclosure can help build trust. When a physician, like Dietrich Niethammer, indicates that he too is struggling with his faith and has not yet received a clear answer, he gives up his position as unchallenged expert and shows solidarity with patients struggling to find their faith. In a study, conducted in the USA, of spiritual pain in cases of advanced cancer,

192 Kuczewski, Talking about Spirituality in the Clinical Setting.

such solidarity was one of the forms of spiritual care that patients found particularly helpful.[193]

The Diversity and Unity of Christian Engagement in Global Health

To end this chapter, let us return to its beginning: to Christian engagement in increasingly globalised healthcare. Regarding the question what Christian actors can contribute to global developments, Miroslav Volf writes that the promise of the biblical "visions of flourishing is a prize jewel in the treasury of the Christian faith, one of its best gifts to the world".[194] The Christian call to healing is guided by such a vision of human flourishing. Drawing on the spiritual care models outlined above, a rough distinction can be made between professional, political and voluntary answers to this call. Put in pneumatological terms: God's healing power is imparted through therapeutic and political action, through solidarity and through explicitly religious acts. The church has a duty to promote, coordinate and stimulate interaction between those answering the Christian call to healing in diverse ways. The more complex, specialised and globalised healthcare becomes, the more important coordination and networking are.

This is another area in which the World Council of Churches has done important preparatory work. The *Ecumenical Global Health Strategy* developed by the WCC in recent years has five objectives:

1. To promote scientific and ethical reflection on health matters from a Christian perspective […].
2. To promote theological and biblical reflection on health and healing […].
3. To promote the health-promoting churches concept: to support church congregations as healing communities to take

193 Mako/Galek/Poppito, Spiritual Pain among Patients with Advanced Cancer in Palliative Care, 1111.

194 Volf, Flourishing, xi.

holistic action on health, especially health promotion and disease prevention, in collaboration with other actors.

4. To strengthen documentation of ecumenical health work: to strengthen sustainable mechanisms of documenting the work of ecumenical partners on health and healing to enable evidence-based decisions at all levels.
5. To support advocacy, networking and capacity building for ecumenical engagement on global health: to support and strengthen sustainable ecumenical engagement on global health through effective networking, advocacy and capacity building at regional and global level.[195]

The WCC combines an international perspective with a concern for local practices. It builds on the concept of "healing congregations", developed at the first conference in Tübingen in 1964 and complemented in the 1990s by the concept of "religious health assets", which refers to the health-promoting capacities – theologically speaking: "talents" – that church communities possess.[196]

As observed in the first chapter, nurses, doctors and chaplains all contributed to the development of Christian spiritual care over the course of the 20th century. Moreover, clinical social workers, psychotherapists and other health professionals can also understand their work as an answer to the Christian call for healing. Each professional group has its own talent to bring to bear within the context of interprofessional spiritual care. The contribution of each of these professions merits closer analysis, validation and encouragement. If I focus on chaplaincy in this book, it is because of its special role within interprofessional spiritual care: In virtue of their training and role, healthcare chaplains are specialists in a field in which nurses, doctors and other healthcare or social professionals are primary care givers.

195 Van Rooyen, A New Health Impetus for WCC.

196 Cochrane, Religion, Public Health and Church for the 21st Century, 63: "The language of assets, in the context of contemporary development theories about sustainable livelihoods and people-centred development practices, points to what people have available to them, no matter how disadvantaged they may be materially, politically and in other ways".

In order to clarify the tasks specific to this role, it is common to distinguish between general and specialised spiritual care. This distinction emphasises the difference in degrees of specialisation and training, which can be understood analogously to that between general practitioners and specialists.[197] Doctors, nurses and members of other clinical professions contribute to the provision of general spiritual care when they consciously attend to the spiritual dimension in their work (and, to this end, develop additional expertise that is appropriate to their field of work). In contrast, for healthcare chaplains, spiritual care is at the centre of their professional activity.

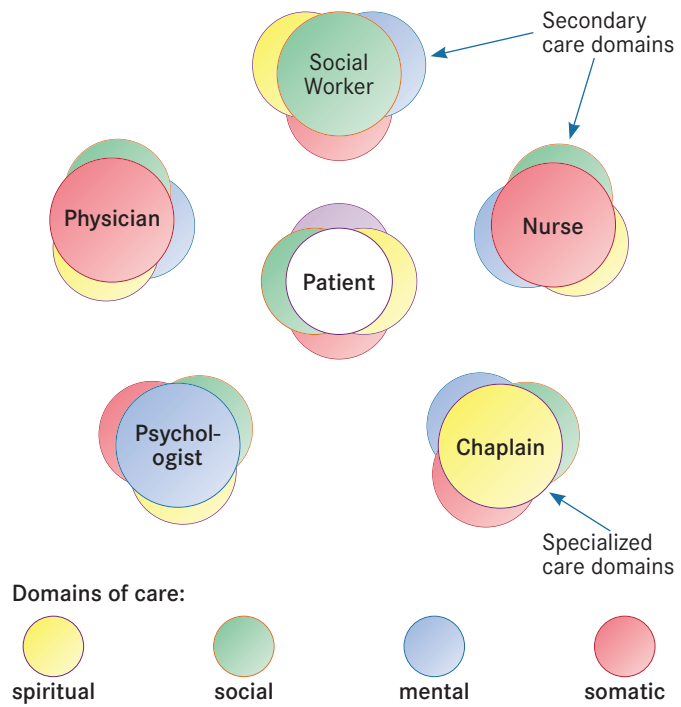

Fig. 5: Professional domains[198]

197 Hagen/Raischl, Allgemeine und spezielle Kompetenzen in Spiritual Care.
198 Following Sinclair/Chochinov, The role of chaplains within oncology interdisciplinary teams.

The distinction between generalist and specialised spiritual care helps to keep in view what is distinctive about the complementary professional approaches and relate them to each other. Given the considerable communicative and organisational challenges facing interprofessional cooperation in clinical contexts, chaplaincy as specialised spiritual care may well have to take on further coordinating, advisory and quality-assurance tasks in the future. If the implementation of interprofessional spiritual care is successful, it will lead to an institutional enhancement of healthcare chaplaincy.

From a theological perspective, however, specialised spiritual care also differs from general spiritual care in virtue of its special mandate and in the representational role of chaplains. Through their commission and their personal spiritual rootedness, chaplains are established as spiritual "intermediaries of trust".[199] They are distinguished *ex professo* by the fact that their own situation in the field of religion and spirituality is, to a certain extent, connected to their professional role and must therefore be declared. In the context of the Christian call to healing, they represent a particular faith tradition in a secular health institution, but at the same time they are points of contact for religious and spiritual questions and concerns in general. To the extent that healthcare chaplains see themselves as sharing responsibility for the mandate of the healthcare institution, they are also intermediaries of trust in the service of patient-centred medicine and care, which are likewise dependent on patients' trust.[200]

It is a strength of the distinction between generalist and specialised spiritual care that it places equal emphasis on their common task and interrelations, on the one hand, and on their differing degrees of specialisation and responsibilities, on the other hand. Furthermore, it has the potential for further differentiation in two directions: While general spiritual care can be further divided into

199 Cf. Peng-Keller, Kommunikation des Vertrauens in der Seelsorge.

200 Such interaction between medicine and chaplaincy is not merely a modern phenomenon, as shown by Nolte, Todkrank, 191. Until well into the 19th century some rural pastors also practised medicine, and academic medics wrote instructions for them on pastoral medicine, primary medical care and guidance on healthy lifestyles. Last but not least, it was hoped that chaplains would foster trust in doctors.

nursing, medical, and psychotherapeutic spiritual care; specialist spiritual care can be divided into Christian, Muslim, Jewish and other variants. Which talents does healthcare chaplaincy, as specialised spiritual care, bring to global health? The third part of this book is dedicated to this question.

III Healthcare Chaplaincy as Specialised Spiritual Care

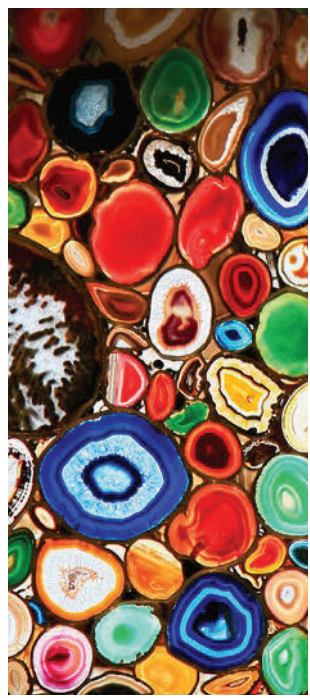

Fig.: Sigmar Polke, Agate window at the entry of the Grossmünster, Zürich (cutout) (© AdobeStock/juhanson)

https://doi.org/10.13109/9783666600319 | CC BY-NC-ND 4.0

The idea of working with slices of agate came to Sigmar Polke while he was looking at a well-known 13th century illumination in which the Divine Wisdom creates the cosmos with a compass.[201] The fallow, blue and black banded cosmic disc, emerging in the hands of the divine artist against a golden background, is reminiscent of the luminous agate slices that Polke would choose for Zurich's Grossmünster. From these slices the artist formed seven richly coloured windows, which, although they face outwards, open an inward view into matter, into the depths of time. Within the stones, it seems, processes are still unfolding. Looking at them, you have the impression that you are witnessing an emergent event, in which the contours of a future reality are slowly revealing themselves.

Similarly, healthcare chaplaincy's incremental development towards becoming a specialised profession in healthcare resembles an emergent process in which fixed forms are only beginning to emerge. Much is still in flux. What can be seen now are not the final contours, but rather fluid opening figures. In the third part of this book, these figures will be traced and elucidated. In the context of interprofessional spiritual care, chaplaincy is to be distinguished as specialised spiritual care.

201 Codex Vindobonensis 2554, f. 1v, Österreichische Nationalbibliothek.

5 Healthcare Chaplaincy as an Answer to the Christian Call to Healing

In the last chapter I joined the World Council of Churches in emphasising that the Christian call to healing is not restricted to any particular form but should be seen as a fundamental church mission. Christian healthcare chaplaincy is located *within* this common mission and is a specification of it. Such an understanding leads to a salutary self-relativisation of healthcare chaplaincy. In its efforts to keep the spiritual dimension alive in a secular healthcare system, it is not alone. Its spiritual mission is rooted in the Christian call to healing, which precedes the mandate of any particular church and is implemented by it. But what does it mean to understand the role of healthcare chaplaincy task this way? Are chaplains meant to contribute to 'heal' patients? And if so, what does 'heal' refer to here? Is chaplaincy to be understood therapeutically?

Case study: Chaplaincy in the neonatal unit

Let us begin with a case report which bring out the healing quality of healthcare chaplaincy and highlights the importance of interprofessional integration. The report was written by chaplain Patrick Jinks, who published it in 2018 together with commentaries from Hans Evers and Jennifer Baird.[202] It centres on a child with trisomy 18, referred to in the report as Sarah, and her mother, Jessica James. The first chaplaincy encounter takes place shortly after the diagnosis of the trisomy in the 30th week of pregnancy. A nurse from the palliative care team perceives the mother's spiritual needs and brings Jinks on board as the attending chaplain. Mrs. James tells the chaplain about her background, her faith, her three-year-old son, Jackson, her hus-

202 Jinks, 'She's already done so much'. Jinks also presents this care in a webinar: https://www.youtube.com/watch?v=DxLIYiRZPek (16.10.2020).

band's professional difficulties, the Pentecostal church community that she misses, and her hope that she will be able to hold the child she has longed for in her arms, if only for a short time. She doesn't trust the medical care team. She doubts that they fully respect and support her wish to carry the child to term and deliver it alive. After this conversation, Jinks brings these concerns to the attention of the interdisciplinary care team, which eventually succeeds in winning the mother's trust.

Two weeks after the first visit, she gives birth prematurely. Thanks to intensive care interventions, Sarah survives. During a joint visit to the neonatal unit, the parents tell the chaplain how overjoyed they are at the birth of their daughter. Over the following months, Jinks supports the parents as they make difficult decisions about heart surgery and a tracheostomy. During his visits to the neonatal unit, he often spends time with Sarah: "I stopped by her bedside frequently, and on days when she was awake, we would sing children's songs together or play with toys in her crib. Sarah enjoyed it when I would help her clap her hands to the beat of songs. She could not vocalise like a typical infant because of her tracheostomy and ventilator, but she would communicate through smiles and frowns, and by clicking her tongue. Sarah was not developmentally a typical six-month-old baby, but she was able to interact, experience love and affection and be playful."[203]

In the seventh month, her general condition deteriorates. In the presence of the chaplain and the extended family, the doctors explain the critical situation to the parents and obtain their permission to refrain from resuscitative measures in the event of a cardiac arrest. After the doctors have taken their leave, the extended family remains in the hospital room. There is an oppressive silence. After a period of silence, the chaplain offers to pray for Sarah and her parents. In an improvised prayer, he recalls Sarah's birth, which her parents had yearned for so much, and the many hardships that accompanied it. And he recalled the wonderful experiences with which Sarah blessed those close to her during her short life. The prayer changes the atmosphere. It creates a space and a foundation for a final step. Carried along by the trust it

203 Jinks, 'She's already done so much', 62.

> evokes, the mother is able to place her child, who dies shortly afterwards, into God's hands: "It's okay, Sarah, you can go if you're ready. You can go home."[204]

In their commentaries, Hans Evers and Jennifer Baird draw attention to the fact that the chaplain in the report, summarised here, fulfils several mediating functions. He mediates between the parents and the care team, between Sarah and the Pentecostal church community, between the world of the living and that of the dead. Jinks describes himself as a „buoy of hope, and an incarnational assurance of God's presence in the midst of their hospitalisation".[205] This mediating role, which the chaplain's religious background and spiritual attitude does much to enable,[206] is also expressed in the prayers documented in the case report. They give expression to concern and distress, as well as to hope and gratitude. They open a horizon of consolation and trust.

Is chaplaincy, in such a case, of medical relevance to the treatment? And if so, what exactly is its therapeutic effect? And how does a healing chaplaincy relate to medical and nursing care? The following sections seek to answer these questions.

Healing Chaplaincy

Healthcare chaplains are guided in their work by their own understanding of illness, health and healing, as well as by chaplaincy goals. It is a constitutive aim of chaplaincy work to be of assistance to patients and their relatives and to promote the process of healing. All the more surprising, then, that healthcare chaplains are often reluctant to speak of this healing dimension to their work. The treatments of other professions can be described as therapeutic, it seems, but not chaplaincy work.

204 Jinks, 'She's already done so much', 63.
205 Jinks, 'She's already done so much', 63.
206 See for this chapter 7.

Case study: Christoph Morgenthaler's "Systemic Chaplaincy"

This can be illustrated with Christoph Morgenthaler's *Systemic Pastoral Care,* a foundational work which is especially close to therapeutic approaches. The systemic chaplaincy, outlined in this book, is active "in a supportive, curative and preventive perspective".[207] It builds "on healing community" and can moderate processes of change and design "life-cycle ceremonies", which sometimes have a "healing, yes, therapeutic function".[208]

The therapeutic potential of systemic chaplaincy is illustrated and analysed in numerous case studies. It is striking that, although the book describes in detail the therapeutic aspects of spiritual care, chaplaincy is not framed in this way. The conceptual field of the therapeutic is reserved for medical and psychotherapeutic work. In response to his suggestion that healthcare chaplaincy should strive towards good interprofessional cooperation in order to enable "optimal, holistic therapy, care and support",[209] one might ask whether chaplaincy should not itself be regarded as part of such a multimodal therapeutical approach.

There is a personal history behind this conspicuous reluctance to make the therapeutic dimension of chaplaincy explicit, which Morgenthaler explains elsewhere: "I first studied theology, then psychology, which, in combination with a training analysis, changed me. When I went into ministry as a theologian and psychologist, people sought my help primarily as a theologian, but I saw myself just as much as a psychologist. When I said I was also a psychologist, however, people no longer approached me as a theologian, but kept their mouths shut, probably out of caution. For a long time, I was myself unsure whether I should see myself as a theologian with psychological training or as a psychologist with theological training. Today I have a more or less stable identity and see myself as a "theologian changed by psychotherapy".[210]

207 Morgenthaler, Systemische Seelsorge, 16.
208 Morgenthaler, Systemische Seelsorge, 10, 138 and 193.
209 Morgenthaler, Systemische Seelsorge, 290.
210 Morgenthaler, Wie hat Psychotherapie die Seelsorgelehre und -praxis verändert.

What Christoph Morgenthaler says of his own professional self-conception can today be applied to chaplaincy theory as a whole: it is transformed by psychotherapeutic practice and research. And this transformation is not yet over. Due to the factors described in the first part of this book, chaplaincy theory is currently faced with the question how the learning process that began in the first half of the 20th century with CPE can be taken forward, a question with implications for the self-understanding of healthcare chaplaincy. A glance at the research literature reveals a progressive de-theologisation of chaplaincy theory and practice.[211] Albert Nolan epitomizes this development when he calls for chaplaincy to be understood as "a highly specialist form of psychological or (better) psychospiritual therapy that can be understood in terms of what it has in common with the psychological therapies but that also makes its own specific and distinctive contribution to psychospiritual wellbeing".[212] But won't such a strong convergence of healthcare chaplaincy with psychotherapy lead to the self-dissolution of healthcare chaplaincy? To avoid this prospect, healthcare chaplaincy must allow itself to be transformed by psychological and psychotherapeutic approaches in the future, while at the same time sharpening the theological profile of its self-understanding.

To this end, chaplaincy work must be clearly distinguished from psychotherapeutic work, especially in the context of interprofessional cooperation. Chaplaincy does not duplicate the work of psychotherapy. But although chaplains, like social workers and ethics counsellors, do not offer therapies, their work can still have a healing effect in its own way. There is no reason to limit the concept of 'therapy' to medicine and psychology. Such a limitation accords neither with the biblical understanding of this term, nor with the Christian call to healing. It conceals the therapeutic potential of chaplaincy. Dietrich Stollberg saw in such a stipulation a kind of armistice between

211 Developments in Toronto are particularly instructive on this point: O'Connor/Meakes, Three Emerging Spiritual Practices.

212 Nolan Steve, Chaplains' Case Study Research, 99. For criticism, see: Körver, Jacques, Renske Kruizinga, Niels den Toom, Martin Walton, Epilogue, 212.

medicine and chaplaincy, in which chaplaincy marginalises itself or else is marginalised:

> "Where chaplains are willingly tolerated, as long as they do not act 'therapeutically' and as long as they manage not to 'transgress boundaries', this is in order to render the chaplains and their work harmless. […] When real people are involved, the transgression of boundaries cannot be avoided: Chaplaincy is therapeutically relevant because soul and body cannot be separated."[213]

It is no coincidence that Dietrich Stollberg's name has come up again here, since he was one of the most prominent advocates of explicitly therapeutic chaplaincy. In his comprehensive account of the CPE, he claims that by adopting the conversational psychotherapeutic approach of Carl Rogers, chaplaincy became "largely identical with 'client-centred therapy'".[214] However, Stollberg was not content merely to highlight the strong therapeutic orientation of the US chaplaincy movement; he also provided the theological rationale he thought it lacked:

> "The therapeutic character of chaplaincy arises from the wholeness of the human being, who experiences him or herself as an indivisible unity, in relation to the community, to the body and to the spirit. […] Chaplaincy, as communication, encompasses all 'areas' of human existence and therefore has bodily effects just as (e.g. medical) care for the body also has spiritual ones; after all, the overall psychosomatic condition of a person influences the community in which he or she lives, and the community's dynamic, in turn, affects the condition of individual members. […] Chaplaincy as an intervention in the overall psychosocial and psychosomatic fabric of a person therefore cannot fail to be

213 Stollberg, Mein Auftrag, 35.

214 Stollberg, Therapeutische Seelsorge, 137. In the 1940s, Rogers began to refer to his counselling approach as 'psychotherapy', in order to break down the claim of psychiatry and psychoanalysis to be the sole actors in the therapeutic field, cf. Myers-Shirk, Helping the Good Shepherd, 91.

> therapeutically or anti-therapeutically effective. And there is an ethical responsibility to examine targeted chaplaincy communication empirically, together with all its sociological, psychological and somatological effects."[215]

Even though chaplains do not offer treatments and therapies they can, informed by the wishes of the patient, contribute to the achievement of palliative, rehabilitative, preventive or curative goals. If their spiritual care positively influences the way in which patients deal with, interpret and experience illness and the nearness of death, it can also be described as medically relevant for treatment. Chaplaincy is therapeutically effective when patients find more hope, clarity, trust and consolation; when they find a new perspective on their illness; when they are supported in making well-considered end-of-life decisions aligned with their own values; when they are empowered to say goodbye to loved ones in a sustaining way; when they find the strength to trust in God in the midst of their distress.

It should be noted that what has been said about therapeutic chaplaincy also applies to chaplaincy outside healthcare. Clearly chaplaincy in parishes, prisons, schools, the military, etc. can and should be healing. What distinguishes healthcare chaplaincy is that, because of its role in healthcare, it must make the therapeutic dimension of its work more explicit, verifiable, and reliable. It has to justify itself within the context of contemporary medicine.

Healthcare Chaplaincy Objectives

In order to be therapeutically effective, chaplaincy must be clear about its goals and communicate these transparently (to patients, relatives, health professionals, health institutions, etc.). One paradox goal is to be non-directive – in a wholesome way. Every chaplaincy procedure should be examined to see whether and to what extent it is beneficial and therapeutic. What are the goals that guide chap-

215 Stollberg, Mein Auftrag, 40.

laincy work in the health system? And how do these goals relate to the goals of medicine discussed above?

For an open discussion of these questions, it may be helpful to remember that, on these issues, even Richard Cabot, Anton Boisen and Helen Dunbar, the founders of CPE, were by no means in agreement.[216] Guided by his spiritual interpretation of mental illness, Boisen forcefully maintained that such illness can only be cured if its spiritual roots are recognised and addressed. By doing this in an expert and empirically grounded way, healthcare chaplaincy can and should be therapeutically effective. According to Boisen, chaplains have a therapeutic role comparable with that of doctors, with whom they should work as equals.

Cabot, in contrast, conceived of the role of healthcare chaplaincy from a medical perspective. He sees healthcare chaplaincy as having, what is at first glance, a more modest role. The effectiveness of chaplaincy is not on the medical but on the spiritual level. Chaplaincy should contribute to the "spiritual maturation" of those entrusted to its care, to a strengthening of compassion, courage, honesty and determination. Like Cabot, Dunbar was careful to distinguish clearly the domains of medicine and chaplaincy; but, like Boisen, he emphasised that spiritual healing processes also have an impact on physical healing and rehabilitation.

The models of cooperation between medicine and chaplaincy given by Boisen, Cabot and Dunbar differ accordingly. While, for Boisen, it involves cooperation between therapists with different qualifications working towards a common curative goal, for Cabot and Dunbar, it is more a matter of coordination between two (or more) professions independently supporting the same patient at the same time, but in different ways.

The approaches embodied by Boisen and Cabot are instructive for our discussion precisely because they are polar opposites. Both are inclined towards spiritualisation, although this takes them in opposite directions. While Boisen tends to spiritualise mental illness, Cabot tends to restrict the efficacy of chaplaincy to a separate spiritual realm.

216 Cf. the accounts of Stollberg, Therapeutische Seelsorge; and Myers-Shirk, Helping the Good Shepherd.

In the light of the conception of illness and healing outlined above, which emphasises the irreducibility of the spiritual dimension as well as its interconnection with physical, mental and social aspects, Boisen's and Cabot's understandings of healthcare chaplaincy goals must both be revised, and Dunbar's approach must be further developed. It is neither possible nor desirable to limit healthcare chaplaincy to a spiritual zone. Nolens volens, healthcare chaplains influence therapeutic processes with their actions – positively and negatively.

In its multifaceted support for patients, healthcare chaplaincy is therapeutically relevant, both from its own and from a medical perspective. In accompanying patients and their relatives through difficult stages of life and through a complex healthcare system, healthcare chaplaincy is able to make its own contribution to palliative, curative, rehabilitative and preventive processes, as well as to the reduction of disease and therapy-related stress. But this can be reliably achieved only through intensive interprofessional cooperation.

The goal of being a healing presence for those affected by illness and supporting them in their distress provides healthcare chaplains with a benchmark for the purposes of critical self-examination, which is essential for quality assurance. Even in its early days, healthcare chaplaincy training saw the importance of providing an empirical validation and foundation for chaplaincy work and developed forms of documentation, self-reflection and supervision specifically adapted for this purpose. While the use of supervisory case reviews based on verbatims continued for decades, clinical documentation and research receded into the background and needed to be rediscovered a little more than two and a half decades ago. This was accompanied by the demand for results-oriented chaplaincy.

Outcome Orientation as a New Chaplaincy Paradigm?

Professional work in the highly complex and ethically sensitive field of healthcare is assessed according to widely accepted standards and certified training paths. To the extent that chaplaincy care is seen as therapeutic (or "anti-therapeutic" in Stollberg's sense) by the healthcare system, the task is to provide transparent quality control and

assurance. *Outcome Oriented Chaplaincy* is particularly committed to this issue.

Outcome oriented chaplaincy was initiated in the 1990s by Arthur Lucas, who was then working as a healthcare chaplain at Barnes-Jewish Hospital in St. Louis/Missouri. Lucas describes the genesis of this approach as a personal and communal learning process. The Methodist theologian had taken the usual CPE path and internalised Roger's principles. It had been firmly impressed upon him that the renunciation of therapeutic goals was a constitutive feature of healthcare chaplaincy. It was supposed to be precisely this lack of therapeutic intention that made it possible for chaplains to be fully present with people in distress. Under external pressure from hospital management, he and his pastoral care team began a lengthy review during which they discovered that presence and outcome orientation are not necessarily mutually exclusive: "In our investigations we came to the realisation that being present with patients can include an informed intentionality."[217]

All chaplaincy work takes place within the framework of certain objectives. If chaplaincy wants to be beneficial, it must orient itself towards the needs of patients and self-critically assess to what extent its services are actually experienced by patients as supportive and helpful. Lucas demands two things in this context: first, the objectives and observed effects of chaplaincy work should be systematically documented and evaluated for the sake of critical self-examination; second, the effectiveness of chaplaincy work should also be investigated in empirical research projects.[218] In his demand for research into efficacy,[219] Lucas joins the psychotherapeutic turn toward efficacy research in the 1990s, the call for a change from "denomination to profession".[220]

217 Lucas, Introduction, 5.

218 Cf. Cadge, Paging God, 91: "The model focuses not on documenting what chaplains do but on documenting the effects their actions have."

219 For a discussion of different research paradigms see Peng-Keller, ‚Spiritual Care' im Horizont Praktischer Theologie.

220 Cf. Grawe/Donati/Bernauer, Psychotherapie im Wandel. Also: Wampold/Imel, The Great Psychotherapy Debate. For a similar argument, see: de Vries, Berlinger, Cadge, Lost in Translation.

Lucas describes the genesis of outcome-oriented chaplaincy as a kind of conversion process that opened up new horizons for him and his team. Does this amount to a paradigm shift in the history of healthcare chaplaincy? Even if this is how proponents of this approach see it,[221] it is in fact more of a reform, a return to neglected ideas. What outcome oriented chaplaincy emphasises – the clarification of chaplaincy objectives, documentation and empirical chaplaincy research – are ideas that have been associated with CPE since its beginnings.[222] Even if the consequences of a stronger orientation towards efficacy are considerable, it is not clear that this results in a new approach to chaplaincy.[223] The aspiration to pay attention to the effectiveness of chaplaincy work and to review it continually within an appropriate quality management framework is compatible with very different approaches to chaplaincy.

Careful consideration needs to be given to the question whether the proponents of outcome oriented chaplaincy do not tend to give too much weight to chaplaincy *action,* to overestimate the degree to which it is standardisable,[224] and to neglect the importance of *being.*[225] To what extent is outcome oriented chaplaincy in its current form able to integrate that which distinguished CPE over recent decades: its orientation towards presence and process?

What research into efficacy in the field of psychotherapy has shown – that the decisive therapeutic factor is not a specific methodology but

221 Hall/Handzo/Massey, Time to move forward; Peery, Outcome Oriented Chaplaincy.

222 Stollberg, Therapeutische Seelsorge, 139 stated in 1969 that "Americans, in a reversal of European tendencies, tend to overemphasise the empirical", which, however, turns out to be an advantage in practice: "For American poimenics, the value of chaplaincy is measured according to the degree and quality of interpersonal help. There is a similarity between the standards of evaluation of diaconal and those of pastoral work."

223 With regard to Brent Peery, Nolan (Review, 242) remarks "that the paradigm shift […] is less about a shift in practice and more about a shift in presentation; that OOC announces a new way of talking about what we do rather than a new way of doing what we do".

224 This is Steve Nolan's criticism, cf. Handzo/Nolan, Outcomes in Health and Social Care Chaplaincy.

225 Swinton, Professional Identity and Confidence, 162.

the quality of the relationship – applies equally to chaplaincy. According to a study conducted in Germany, what is expected of chaplaincy is "more in the area of psychosocial or therapeutic, interpersonal support than in the area of religious and spiritual support".[226] The interpersonal competence of the chaplains was shown to have the greatest impact, along with the ability to interact with churchgoers and the unaffiliated alike in such a way that all feel understood and accepted when seeking help and advice.[227] "Many addressees share their astonishment at their unexpectedly therapeutic experience of church traditions when these were offered to them by a chaplain listening to their psychosocial concerns."[228]

In view of the demand for chaplaincy to be more outcome oriented, this study can be read in two ways: on the one hand, as proof of the value and relevance of efficacy research and monitoring in the field of chaplaincy care; on the other hand, as a vindication of the core concern of those forms of communicative chaplaincy which are based on mindful presence and able to draw on ritual practices. To be fully effective and therapeutic, chaplaincy must clearly formulate its goals (which include a non-directive approach) and navigate the paradox of intentionality that characterises it: the paradox of an intentional non-intentionality. This is based on trust in a powerful presence, which is revered in Christianity as the Holy Spirit. In the next section, we shall explore this further.

Presence and Reframing: Dimensions of Healing Chaplaincy

What makes chaplaincy therapeutic? If one looks to chaplaincy literature for an answer, one finds several paths, two of which are particularly clear: One leads to experiences of *healing presence,* through which connectedness, closeness and acceptance can be experienced; the other leads to processes of *reframing,* through which horizons of

226 Lammer, Wie Seelsorge wirkt, 321.
227 Lammer, Wie Seelsorge wirkt, 323.
228 Lammer, Wie Seelsorge wirkt, 324.

meaning and new life connections open up.[229] Simply put, both of these paths which healing chaplaincy follows are about shaping relationships and interpreting life in the context of what chaplains seek to represent and embody – on the Christian understanding: God's presence.[230] With reference to the case study introduced at the beginning, chaplaincy in the neonatal unit, I shall describe both paths in more detail – and at the same time attempt to bring together the lines of thought developed in the preceding chapters. In order to relate this once again to the Christian call to healing, I will first turn to a New Testament story in which we find both of the aspects mentioned.

Case study: The healing of the blind man at Bethsaida (Mk 8:22–26)

If the New Testament healing stories are understood as a matrix for the Christian call to healing, as suggested here, then the procedural aspects of the story of the healing of the blind man at Bethsaida are particularly striking. Although the healing procedure employed by Jesus is more elaborate than usual – he takes the blind man by the hand, leads him out of the village, puts saliva on his eyes and lays his hands on him – the healing does not succeed straight away. At the first attempt, the blind man begins to see the outlines of people and compares them to trees walking. But only after Jesus lays hands on him again does he see clearly. The South African theologian Yolanda Dreyer has suggested that this should be understood as an indication of a complex, multi-stage healing process, which also involves those who allow this story to affect them and, through it, find a new vision of the world.[231]

Looking at Jesus himself, at his bodily and chaplaincy actions, it is remarkable how intensively he touches the blind man. He seeks a safe place, free from disturbances, to perform this touching procedure. And so he takes the blind person by the hand and leads him out of the hustle and

229 See also Swinton/Kelly, Contextual Issues, where the authors emphasise both aspects in their plea to understand healthcare chaplaincy as a healing and healthcare profession.

230 For empirical evidence of these two basic dimensions, see Winter-Pfändler/Morgenthaler, Wie zufrieden sind Patientinnen und Patienten mit der Krankenhausseelsorge?

231 Dreyer, Material poverty and the poverty of excess.

bustle. The healing touch takes place in a secluded place: healing requires mindful presence. The delicate touch is followed by a few words – not many, but all the more powerful for that. Dialogue is needed for the visual fine-tuning, for the development of a new perspective. Here we find interwoven the two therapeutic moments that will be examined in more detail below: healing presence and liberating processes of meaning formation.[232]

Although the healing closeness comes *before* the dialogical sharpening of vision in this healing narrative, as in the Road to Emmaus story, this order is reversed in the experience of the reader. By reading the narrative and entering into the world of the story, your vision is refigured in such a way that you are led into an unnoticed presence. It is to this linguistically mediated formation of meaning that I now turn.

Fractures of Meaning in Liminal Situations

Healthcare chaplaincy communication often takes place at the edge of language and experience, feeling its way along the fractures of meaning, in liminal situations where everything that sustains life and makes it meaningful threatens to collapse, but where sometimes an abundance of meaning announces itself that is difficult to capture in language. The stories that chaplains hear are often fragmentary – the meaning of the fragments is not readily apparent, and the overall context is often elusive. As in the following chaplain's case study:

Case study: "É como uma bruxa!"

"Mrs F., a 25-year-old patient with Portuguese roots, came to our palliative care unit with advanced cancer. Although she received a high dose of morphine, she was still in pain and remained alert. Her struggle was

232 The three basic models of contemporary spiritual care described in the first chapter accentuate and configure these two moments in different ways. It makes a difference, for example, whether "healing presence" is understood as being more firmly established in "face to face" encounters or in the energising laying on of hands.

> quite palpable as she was supported over the course of a little more than a week. She said several times that she wanted to live. During our last conversation, a day or two before she died, she described her condition to me with the following words: 'É como uma bruxa!' 'It's like a witch', she translated. That was one of the last things she said. On my last visit, when I took my leave of her, she was no longer conscious."[233]

The dying young woman's description, first formulated in the Portuguese of her mother tongue, is a pregnant expression of her "total pain". The chaplain told me that it was no longer possible to talk to Mrs F. about this forceful image and to explore with her what it meant. She was too tired and weak by this point. How she understood her own statement itself therefore remains uncertain. And this is also relevant. Healthcare chaplaincy helps patients search for meaning in the face of the absurd and the incomprehensible. There is much to suggest that the metaphorical statements that dying people choose to describe their experience are attempts to express the fragile relationship between meaning and absurdity.[234] In one respect, this is not unusual, as it applies at some level to much of human communication. Doris Lessing put it this way in her Nobel Prize speech: "… it is our imaginations which shape us, keep us, create us – for good and for ill. It is our stories that will recreate us, when we are torn, hurt, even destroyed. It is the storyteller, the dream-maker, the myth-maker, that is our phoenix, that represents us at our best, and at our most creative."[235]

Chaplaincy can have a healing effect at the breaking points of meaning if it offers space for imagination and narration, if it takes up and gives recognition to fragments of stories and metaphors, if it talks the language of the afflicted and so stays close to them. In the case report from the neonatal unit quoted at the beginning, the chaplains at the deathbed of terminally ill Sarah says a prayer in which

233 The example is from a research project on imaginative experience near death, cf. http://p3.snf.ch/project-145093 (16.10.2020).
234 Cf. Peng-Keller, Symbolsprachen Sterbender.
235 Lessing, Nobel Lecture.

the profound experiences of the past months find expression. In the mode of thanksgiving, he brings to mind Sarah's short life, the gift of her birth and her being. Through his prayer in the presence of the extended family, the distress of the farewell is framed in terms of life and faith, opening a horizon to a communion that spans the abyss of death. In this way, the chaplain makes room for healing. His prayer enables the mother to place her dying child in God's hands: "It's okay, Sarah, you can go if you're ready. You can go home. "[236]

The Scottish theologian John Swinton sees the prophetic task of healthcare chaplaincy as contributing "a form of transformative imagination that offers both challenge and the potential for healing".[237] Because such imagination is conveyed especially through the narrative medium, Swinton sees chaplaincy work as "narrative negotiation and narrative healing".[238] But these terms put too much emphasis on the deliberate interventions of chaplains. In contrast, it should be stressed: "transformative imagination" is already at work before chaplains enter the stage. Often, they find themselves in the role of mindful witnesses who heal through "evocative presence" (see below). As in the following case:

Case study: From leafless beech to flowering tree of life

"Mrs O., an elderly patient with terminal cancer, points out to me in conversation the beautiful, large beech tree that towers above the hospital garden in front of her window. It is autumn and it has already lost many leaves. Mrs O. sees herself reflected in it. She too must cope with losses and say goodbye to many. Like the beech tree, she will soon have lost all her blossom and all her leaves. She does not say this tearfully, but very in a dignified and composed way. Suddenly she begins to smile and tells me about a lime tree that was important in her life. This lime tree, which stood in the middle of a field, was the place where Mrs O. used to meet her future groom before their wedding. Mrs O. then tells me that she imagines that this lime tree is blossoming blissfully in paradise

236 Jinks, 'She's already done so much', 63.
237 Swinton, Afterword, 300.
238 Swinton, Afterword, 301.

> and that she will meet her deceased husband once more under it. As I say goodbye to her, there is a gentle smile on her face."[239]

The chaplain provides Mrs O. with a resonance chamber in which the power of imagination can unfold and deepen. The leafless beech tree, which she perceives as her mirror image, is transformed over the course of the conversation into a vernal lime tree, a flight of imagination in which a felicitous past turns into a promising future. On the verge of death, the depth of this life is brought into the light through reverie and the anticipation of a joyful reunion.

Chaplains often navigate the margins of clinical worlds defined by biomedical success stories. During their visits, they dive into the intermediate realm of daydreaming hope and everyday storytelling in which clinical reality is imaginatively transcended. This is especially true for testimonies of visionary experiences, which are difficult to communicate, partly because they are often treated with suspicion as potentially pathological.[240] Through gentle enquiry, chaplains encourage people to tell their stories, give them space and validate what they share.

Although in many situations it is best chaplaincy practice to attentively support and accompany processes of narrative and imaginative meaning-making without actively directing them, it is sometimes necessary to take an interventional and structured approach, as in the following example of prolonged end-of-life care:

> Case study: "I have to go home urgently"
>
> "Mrs L., who was between 50 and 60 years old, lay for weeks in the oncology ward with terminal cancer. She was already extremely weak and could only speak very indistinctly. The doctors and nurses had been expecting her death for some time and were surprised that she was still alive. It was very difficult for the nursing staff to deal with her. Her continued restlessness and her endless, unintelligible shouting were extremely onerous. The snatches of words and sentences could

239 Peng-Keller, Symbolische Kommunikation in Todesnähe, 133.
240 Peng-Keller, Sinnereignisse in Todesnähe.

be understood as a desperate plea to go home. Whenever Mrs L. saw that someone was coming near her, she started calling for help.

That was also my first experience with her. Dialogue was not possible with her. Clarificatory questions did not seem to get through to her. All I could do was listen carefully and observe – and occasionally confirm that I heard her calls, although I did not yet understand them. From the third visit onwards, her cries for help gradually became more understandable to me. I tried to piece together the snippets of words and sentences, which was all the more difficult as I did not know Mrs L. and had no idea about her life and background. It was like assembling a jigsaw puzzle with missing pieces. Piecing together the meaning of her cries in this way, I took her to be saying: "I urgently need to go home to do something, to put something in order." When I told her what I thought I had understood, she reacted violently without being able to express herself intelligibly. This seemed to mean: "Well, if you have understood, then help me immediately, now!"

After my initial uncertainty, I came to see how I could help her to calm down and let go. During the following visits, which lasted between 45 and 60 minutes, I gently and in small steps told her what I perceived and thought I understood:

"You're desperate to get something done, to get something in order."

"It worries you a lot, it scares you that you can't get it done."

"I see how much you feel responsible."

"You have good intentions. More is not required in your situation."

"You can be confident; everything will be all right now."

Between the statements I tried to see whether I was getting through to Mrs L. She was indeed becoming increasingly calm. As I learned from the nursing staff, however, the effect only lasted for about half an hour to begin with. I was now visiting Mrs L. every day, always saying the same thing to her in the same way, and this became a ritual. Step by step and in the same words, if possible, I walked the same path with her again and again. Little by little, Mrs L. settled into a longer-lasting calm. She died a good two weeks after I had first visited her."[241]

241 Peng-Keller, Symbolische Kommunikation in Todesnähe, 135.

As in Patrick Jink's case report, the chaplaincy intervention in this example is interprofessionally embedded. In collaboration with the care team, the chaplain supports Mrs L., focusing on the obscure meaning of her urgent appeal. He perceives ever more clearly Mrs L.'s desire to put something in order at all costs, as well as her desperation at no longer being able to do this. The precise perception of Mrs L.'s distress provides the basis for the further steps.

The approach taken is determined by the objective of responding as precisely as possible to the spiritual and mental distress perceived and thus alleviating it. To this end, several longer visits are scheduled, during which the chaplain verbalises and validates Mrs L.'s plight and repeatedly assures her that her good intentions are what count and that "everything will be all right now". Isn't he promising her much more than can be gathered from the immediate situation? Does his "everything will be all right now" express his personal conviction, or does it merely reflect the fact that chaplaincy is expected to give people comfort? Why does the comfort in this case not seem superficial?

In trying to establish what makes chaplaincy therapeutic, we have reached a critical point; for on the one hand, all the characteristics of healing chaplaincy are evident in the procedure just outlined; on the other hand, it is widely accepted that momentary comfort is not healing. How can chaplaincy avoid falling into this trap in its effort to bring "a form of transformative imagination that offers both challenge and the potential for healing"?[242]

Donald Capps illustrates the problem through a comparison with Job's friends.[243] Eliphaz chooses the path of supportive chaplaincy and tries to activate Job's spiritual resources: "Call now […] I would seek God, and to God I would commit my cause. He does great things and unsearchable, marvellous things without number" (5:1, 8 f.). Bildad reminds Job of the reliability of the tradition that had been passed down and encourages him to be guided by it (8:8–10). Zofar, who remains silent the longest, tries to placate Job with instruction (20:1–29). But neither appeal, nor exhortation, nor teaching comfort Job. Quite the opposite: the speeches of these friends, whose

242 Swinton, Afterword, 300.
243 Capps, Reframing, 111 ff.

long-windedness bore readers to this day, are irksome and do nothing to help the afflicted. Well-meant words of consolation cannot comfort Job. What comforts him at the beginning and end of his suffering is the experience of healing presence.

Healing Presence

What chaplains contribute to healing is not only to be found in what they *do,* but also in their ways of *being present.*[244] Healing presence touches preverbal and transverbal dimensions of meaning, the "somatic, emotive or atmospheric depths […] of meaning".[245] Richard Cabot and Russell Dicks drew attention to this dimension of presence when they observed that silence and pauses in conversation can have a therapeutic effect.[246] In a more recent study, this has been described as "compassionate silence" and distinguished from the kind of silent listening that is intended as an invitation to talk. "Compassionate silence" encompasses an attentiveness and openness, an attitude that conveys security and calm, while requiring the spiritual caregiver to be prepared to engage fully with the present moment and patiently to abide with the other person.[247]

We can be sure that it is precisely this kind of engaged presence that makes it possible for the words of comfort words to get through to Mrs L. The farewell prayer in Patrick Jink's case report is likewise preceded by such a silence: "Jessica and Seve both wept silently while the family stood around them in silence. I remained present, lingering quietly in a corner, taking in and accepting the weight of this moment. Sarah was dying."[248] In this moment of silent being, we find in condensed form what Jinks describes as the chaplain's task of

244 Adams, Defining and Operationalizing Chaplain Presence, criticizes rightly an unspecific usage of the term 'presence'. In the following I try to specify this term with regard to chaplaincy as specialized spiritual care assuming that 'healing presence' is also characteristic of generalist spiritual care.

245 Angehrn, Sinn und Nicht-Sinn, 53.

246 Cabot/Dicks, The art of ministering to the sick, 207, 212.

247 Back/Bauer-Wu/Rushton/Halifax, Compassionate silence.

248 Jinks, 'She's already done so much', 63.

embodying God's presence. At this moment, a spiritual dimension to the professional role of the healthcare chaplain opens up, one that is grounded in Jinks' religious convictions. Here, mindful presence is at the same time a professional attitude *and* a spiritual practice.

It is to the lasting credit of Carl R. Rogers that he drew particular attention to the therapeutic relevance of this basic attitude. In view of the persistent temptation towards pastoral interventionism, this legacy of Rogers is of lasting significance, even if such an open presence, attentive to the presence of another, may appear anachronistic in an era of structured efficiency. One could even locate the core of healing chaplaincy here: It unfolds its therapeutic potential when it brings the "anthropological passive"[249] to bear, when it conveys the experience of unconditional acceptance through compassionate presence. As much as chaplains highlight the importance of this qualified presence, it is precisely on this point that the professionalism of chaplaincy is regularly called into question.

In her study of chaplains in health institutions in London, Helen Orchard expressed doubts that an "'empty handed' ideology (or theology)" can form the basis for professional action. For: "while a person can be an expert in matters of religion, the 'empty handed' approach requires no expertise".[250] Orchard's challenge is reminiscent of Arthur Lucas' critical revision of Rogers' approach[251] and the demand for more purposeful and outcome-oriented chaplaincy. Does simply being present at the bedside of the sick and dying require professional expertise? Is this not something that many family members and volunteers can do just as well and for free?

Orchard takes aim at a central component of chaplaincy work and must therefore be taken seriously. In particular, it must be shown to what extent healing presence constitutes a skill that requires special training, and which is perceived and appreciated as such by patients precisely because it cannot be taken for granted in budget-constrained healthcare institutions. Here "compassionate silence" is a

249 Cf. Stoellger, Passivität aus Passion.

250 Orchard, Hospital Chaplaincy, 139; quoted in: Swift, Hospital Chaplaincy in the Twenty-first Century, 184.

251 For a similar critique cf. Grossoehme, Beliefs Nurture Chaplaincy, 81.

scarce commodity. What distinguishes professional chaplaincy is the conscious incorporation of spiritual mindfulness practices in clinical contexts. When Orchard published her widely discussed report in 2000, she could not have anticipated that the healing effects of mindful presence would be intensively investigated and empirically attested in the following decades.[252] As a result of the increasing prevalence of mindfulness-based, evidence-based therapies, it has become easier to substantiate claims for the importance of mindful presence in clinical contexts. However, there has yet to be a comprehensive analysis of the implications for chaplaincy theory of the insights acquired in the context of mindfulness-based therapies and the research that accompanies them.

Against this background, the orientation towards presence that characterises Rogers' approach appears in a new light. Rogers unfolded the healing power inherent in mindful presence in a lecture he gave in 1982:

> "When I can let myself enter softly and delicately, the vulnerable inner world of the other person; when I can temporarily lay aside my views and values and prejudices; when I can let myself be at home in the fright, the concern, the pain, the anger, the tenderness, the confusion, which fills his or her life; when I can move about in that inner world without making judgments; when I can see that world with fresh unfrightened eyes; when I can check the accuracy of my sensing's with him or her being guided by the responses I receive, then I can be a companion to that inner person, pointing to the felt meanings of what is being experienced. Then I find myself to be a true helper, a welcome companion, and aid to growth and help. […] There is another very subtle factor in the healing relationship which I have experienced and that I would call presence. […] When I am at my best as a group facilitator, or a therapist, I discover this characteristic. I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness, then

252 Back/Bauer-Wu/Rushton/Halifax, Compassionate silence.

> what ever I do seems to be full of healing. Then simply my presence is releasing and helpful."[253]

In this lecture, Rogers draws on a passage from his book *A Way of Being,* published in 1980. There, he not only elaborated the therapeutic significance of mindful presence but also acknowledged that this has a spiritual dimension, something to which he admitted he had given too little attention. He was also careful to distinguish the spiritual from the mental:

> "It seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present."[254]

The strength of Roger's therapeutic approach, with which he overcame the moralistic character of previous counselling and chaplaincy approaches during the Second World War,[255] is its embedding of mindful presence in communicative procedures.[256]

What makes such communicative presence therapeutic can be further specified.[257] In a study of spiritual care for the dying, Steve Nolan distinguishes four forms of chaplaincy presence, without paying particular attention to the importance of mindfulness.[258] He characterises the first as *evocative.* It corresponds to what will be discussed below as the symbolic content of the role of chaplain and the associated "transference that begins as soon as a chaplain enters the hos-

253 Rogers, New World – New Person.

254 Rogers, A Way of Being, 129.

255 Myers-Shirk, Helping the Good Shepherd, 90–95.

256 The attempt to integrate mindfulness-based therapeutic methods *as such* into a healthcare chaplaincy practice has yet to prove its worth. In the *US Department of Veterans Affairs* (VA) mentioned above, *Acceptance and Commitment Therapy* (ACT) is already part of clinical chaplaincy training, cf. the case reports by Janet Hanson and Valerie C. Sanders in: Fitchett/Nolan, Case Studies in Spiritual Care.

257 Cf. Miller/Cutshall, The art of being a healing presence.

258 Nolan, Chaplain as 'Hopeful Presence'. See also his: Spiritual Care at the End of Life.

pital room. With her, the whole 'Alpine panorama' of faith, church and Christianity erupts into the room."[259] Chaplaincy is only therapeutic if it is aware of this transference and deals with it consciously. This is especially true where chaplains awaken negative memories and feelings instead of buried spiritual resources.

Case study: Evocative presence

In his analysis of his conversations with chaplains, Nolan notes that even negative transferences can provide an opportunity for healing. One of the chaplains interviewed describes his approach in such situations as the performative correction of preconceived ideas: "You don't run away from it ... if you can stay with that ... you're, kind of working in the opposite direction to it [...] by meeting a religious figure, a perceived religious figure who is different and acts in a way that is different from how they would expect a religious figure to act and behave in terms of attitude and so on – and particularly in terms of acceptance – that may help people to move on in a particular direction".[260] Dealing with negative projections in this way can engender an experience which Nolan characterises with a practical syllogism:

"The chaplain represents God,
the chaplain is not judgemental,
therefore, God may not (after all) be judgemental."[261]

Wolfgang Drechsel gives the following example of this: "A young chaplain enters the hospital room and introduces herself. Patient: 'I don't need chaplaincy. I'll be discharged tomorrow anyway.' Short pause, then sharply: 'And I'm palliative anyway.' And before the chaplain can say a word, vehemently: 'You don't need to look at me like that.' There is nothing more the chaplain can do. She is not permitted to speak, not even to look. She mentions her awkwardness briefly, then says goodbye. In any case, she is very bothered by the situation afterwards.

259 Morgenthaler, Wie hat Psychotherapie die Seelsorgelehre und -praxis verändert.
260 Nolan, Chaplain as 'Hopeful Presence', 171.
261 Nolan, Chaplain as 'Hopeful Presence', 172.

> [...] After a supervision session on the same day, which was about understanding situations in terms of *containment*, the chaplain visits the patient again – to put on record, as it were, that she had survived the previous day's emotional distress. 'I just wanted to drop by again to say goodbye in case you're being discharged.' 'Oh, it's nice of you to come again' – and they have a long, touching conversation in which the patient lays out her history of illness, her despair and all that had been concealed in those three sentences the previous day."[262]

The second form of chaplaincy presence Nolan calls *accompanying* presence. The chaplains interviewed describe this as entering the mystery of the person they are accompanying, as bearing their distress and despair without trying to achieve anything in particular thereby. The fact that the young chaplain in the case just cited went back to the patient, venturing once again into her distress, is an example of such chaplaincy containment. The third form of chaplaincy presence is described by Nolan as *comforting* and is similar to what was described above as "compassionate silence", as illustrated by the example with Patrick Jinks.

Case study: Comforting digital presence

In his account, Nolan naturally assumes, in common with previous chaplaincy discussions, that chaplaincy presence requires physical presence. But the experience shows that chaplaincy presence is possible even at a physical distance. These possibilities have expanded even further, as a result of technological developments and the Corona pandemic.[263] In an Irish study about the support of patients who could no longer be visited due to pandemic-related restrictions, Michael Byrne and Daniel Nuzum describe experiences of chaplaincy encounters via video call and with tablets: "At a time of fear, isolation, and uncertainty, the use of this technology restored a sense of dignity, and it allowed the pastoral relationship to form and flourish. In a situation where

262 Drechsel, Sterbenarrative aus der Sicht der Krankenhausseelsorge, 246.
263 Winiger, The changing face of spiritual care.

> patients meet all staff dressed in PPE, one of the immediate benefits of using a virtual video chaplaincy service was that there was no need to wear PPE; therefore, the patient can see and be seen face to face. The use of technology in this way overcame the inevitable barrier of PPE, thereby reducing the depersonalization and "othering" of both patient and chaplain. Pastoral ministry is dependent on our ability to read social cues, eye contact, silence, smiling, and nodding, in order to let patients know that they are being heard and seen."[264]

Finally, Nolan describes as *hopeful presence* the paradox of arriving and abiding together in a present full of hope, although all hope of a cure is gone. While Nolan's distinctions and descriptions require further refinement, they are a commendable attempt to explore how healthcare chaplaincy professionalism can prove its worth, especially in forms of mindful non-action and presence that have been honed through demanding learning processes. But can it be shown that such chaplaincy presence is in fact healing? The results of the German study cited above point in this direction. Another source, which should not be underestimated, is patients' narratives of sickness and death, in which the impact of chaplaincy can be seen. One example of this is the following account from children's rights activist and Nobel Prize laureate Malala Yousafzai.

Case study: Rehabilitative Muslim chaplaincy

> "I woke up on 16 October, a week after the shooting [at the 9th October 2012]. I was thousands of miles away from home with a tube in my neck to help me breathe and unable to speak. I was on the way back to critical care after another CT scan, and flitted between consciousness and sleep until I woke properly. The first thing I thought when I came round was, Thank God I'm not dead. But I had no idea where I was. I knew I was not in my homeland. The nurses and doctors were speaking English though they seemed to all be from different countries. I was speaking to them but no one could hear me because of the tube in my neck. To start with

264 Byrne/Nuzum, Pastoral Closeness in Physical Distancing, 7.

> my left eye was very blurry and everyone had two noses and four eyes. All sorts of questions flew through my waking brain: Where was I? Who had brought me there? Where were my parents? Was my father alive? I was terrified. [...] The only thing I knew was that Allah had blessed me with a new life. A nice lady in a head scarf held my hand and said, 'as-salamu alaikum,' which is our traditional Muslim greeting. Then she started to sing prayers in Urdu and reciting verses of the Koran. She told me her name was Rehanah, and she was the Muslim chaplain. Her voice was soft and her words were soothing, and I drifted back to sleep."[265]

Let us return to the question posed at the beginning of this chapter: What makes chaplaincy therapeutic? I have suggested that two experiential dimensions of chaplaincy encounters are key: meaning formation in liminal situations, and healing presence. The case studies given show that these two dimensions are closely intertwined. This is especially true for ritual practices.

Case Study: Aaronic blessing (Num 6:24–26)

Kerstin Lammer draws attention to the fact that where the Aaronic blessing is pronounced with outstretched hands this recalls a primal humane experience: the mother's radiant countenance: "To be touched and held, to be seen and to see the other's face shining. Eyes that shine because they see you – I believe the secret of the Aaronic blessing is that it speaks to our deep archaic longing to be looked at lovingly in that way."[266] The gesture of blessing and the attention associated with it embody what the words of blessing make audible: the primal experience of being affirmed and of finding oneself in the gaze of another. Lammer illustrates the significance of this blessing for spiritual care with the following case study:

265 Yousafzai/Lamb, I am Malala, 275 f. I am grateful to Dilek Uçac-Ekinci for bringing my attention to this passage. Here I should mention that "healing chaplaincy" is, of course, also to be found in Muslim, Jewish and other forms.

266 I am quoting from an unpublished first version of: Lammer, Blessing. I am grateful to Kerstin Lammer for making this version available to me.

> A chaplain "visits Mr D., early 50s, head of a government agency, on the eve of a major operation. In conversation Mr D. is entirely focussed on the topic of his work: what he had done or delegated before his stay at the hospital, what will be difficult without him, when he will return to work and what will have to be done at that point. When asked about the upcoming operation, Mr D. explains technical details and the success rate of such surgery in a seemingly detached manner; he does not express his own feelings and thoughts. Mr D. signals that he wants to end the conversation. The chaplain offers to bless him. To her surprise, Mr D agrees immediately. As the chaplain lays her hand on him and says: 'The Lord bless you and keep you; the Lord make his face to shine upon you, and be gracious to you; the Lord lift up his countenance upon you, and give you peace' [...], tears come to Mr D.'s eyes. He grips the chaplain's hand. Silently and with eyes closed, he holds it tight for a while. Then he opens his eyes and says: 'Maybe it will be all right after all. Thank you!'"[267]

Summary

In the context of the Christian call to healing, to which the second part of this book is dedicated, healthcare chaplains share responsibility for providing professional and compassionate healthcare. They can foster health and healing in palliative, rehabilitative, preventive and curative medicine. Healthcare is not a purely medical or clinical matter, but the responsibility of a wide range of professions: It needs to be organised socially and politically and is bound by guidelines on fundamental rights and ethics.

The work of healthcare chaplaincy must be measured against general ethical and therapeutic criteria as well as against its own aspiration to support and comfort the suffering. It is an intrinsic goal of healthcare chaplaincy to be beneficial and, ideally, therapeutic: to help seriously ill people and their relatives find comfort, clarity and hope in emergencies of all kinds. Since healthcare chap-

267 Lammer, Segnen, 229 f.

laincy deals with highly vulnerable people, professional responsibility demands reliable structures for quality assurance. The credibility of hospital chaplaincy was not helped by the fact that, for a long time, it moved largely under the radar of therapeutic quality control, often with "incredible independence".[268] So, how can chaplaincy demonstrate that it is indeed meeting external expectations and its own standards?

The response of *outcome-oriented chaplaincy* to this question is to call for a clarification of chaplaincy objectives and to try to provide a basis for these objectives to be empirically assessed. Contrary to the self-understanding of some of its proponents, however, this is not a paradigm shift in the history of healthcare chaplaincy, but a development consistent with the goals of the 20th century chaplaincy movement. As we have seen, its founding figures – Richard Cabot, Anton Boisen and Helen Dunbar – were guided by the conviction that clinically trained chaplains can contribute in a particular way to patients' well-being and should therefore always be included in interprofessional cooperation – in a similar way to the clinical social work initiated by Cabot.

This means renouncing the "incredible independence", but it doesn't mean giving up chaplaincy's professional self-understanding and spiritual profile. The assumption that spiritual care can be therapeutically relevant does not mean that the purpose of chaplaincy is limited to its contribution to medical goals. Nor does it follow that chaplaincy will become part of a medical treatment plan and have to implement medical decisions. On the contrary, the more clearly chaplaincy can articulate what it can contribute to interprofessional care, the more likely it is that its contributions will be perceived as unique and important for common healthcare goals.

It is high time that we do away with the outdated though still influential notion that healthcare is primarily the responsibility of doctors, while other professionals are second-tier support staff, waiting to be called upon as needed, like altar boys assisting priests. The role of healthcare chaplains in interprofessional teams is similar to that of clinical ethicists and social workers. The critical and advisory

268 Spoerri, Spitalseelsorge als Anachronismus, 143.

work of clinical ethicists requires a degree of independence from the medical and nursing team; and clinical social work is assessed according to objectives that are clearly distinguishable from medical objectives. The same can be said of chaplaincy as specialised spiritual care. This brings us to the next chapter.

6 Chaplaincy as a Specialised Profession within Healthcare

In her landmark study *Paging God,* Wendy Cadge distinguishes "professional" from "traditional" chaplaincy departments.[269] One might wonder whether professional healthcare chaplaincy has not been the standard for a long time. Isn't this precisely what the CPE has been trying to achieve since it began in 1925? Can there be any doubt that healthcare chaplains, who must have an academic degree and specialist training, are doing professional work?

In her report, *Hospital Chaplaincy: Modern, Dependable?* Helen Orchard raises critical questions in this regard. On the basis of an extensive field study in London, connected to the New Labour government reforms outlined above (see chapter 2), she calls attention to the largely unstandardised practices, the lack of accountability of chaplains, the sometimes inadequate training, and unclarity in its professional profile.[270] If the CPE of the 20th century represented the first phase of the professionalisation of healthcare chaplaincy, then current developments can be thought of as a second phase of an ongoing process, which has gained new momentum. The drivers of this development were described in the first part of this book. It may be heard as a wake-up call: It is *Time to move forward …* [271] What are the features of this second professionalization shift? Let us turn briefly to the sociology of professions. Sociologist Michaela Pfadenhauer identifies three qualities that characterise a profession:

269 Cadge, Paging God, 115–121.

270 Orchard, Hospital Chaplaincy. For an appraisal and critique of this report, see Swift, Hospital Chaplaincy in the Twenty-first Century, 60–62 and 184.

271 Hall, Handzo, Massey, Time to move forward.

> "1) occupational, hence 'professional', knowledge, that is sometimes specified as 'theoretical', 2) the clear, usually formal legal definition of the field of activity coupled with a monopolisation of this field on the basis of this knowledge, often in an institutionalised form (professional qualification), as well as 3) the formation of professional associations for the self-administration of the profession, with its distinctive body of knowledge and professional practices and/or an orientation towards the common good (often understood altruistically)".[272]

For our discussion, this means: To gain (or retain) recognition as a profession in a rapidly changing and increasingly complex professional environment, healthcare chaplaincy must specify the nature of its expertise and define its role within healthcare.[273] The specialisation for spiritual care can be demonstrated through both expert *knowledge* and through *practical competences.* The latter is the more controversial: what are the specific competences that characterise chaplaincy as a profession within the health system?

Distinguishing Roles and the Task of Integration

It was and remains one of the central goals of CPE to support prospective chaplains in the integration of "disparate parts of one's personality into one's identity".[274] The differentiation of competences and skills distinctive to healthcare chaplaincy necessitates an analogous task of integrating the professional role of chaplains. In a 2007 article, Brigitte Amrein, who was head of chaplaincy at the Cantonal Hospital in Lucerne for over two decades, lists the following tasks in addition to pastoral conversations with patients and relatives:

272 Pfadenhauer/Sander, Professionssoziologie, 362.
273 Mieg 2005.
274 Grossoehme, The Role of Science in Enhancing Spiritual Care Practice, 94.

> "Organising celebrations for patients and staff, in cooperation with the nursing team, recruiting, training and supervising the night watch volunteers, teaching at colleges for health professions, adult education, training theologians, public outreach. A recent addition for us is training in emergency chaplaincy and debriefing."[275]

In recent years, the responsibilities of hospital chaplains have multiplied further. Of particular importance is the increasing involvement of chaplains in ethics counselling, ethics committees and other interprofessional working groups. Where is the organising principle that unites all these heterogeneous activities? Is the diversity of healthcare chaplaincy responsibilities a symptom of an ill-defined professional role[276] or, conversely, proof of how useful the inherent flexibility of healthcare chaplaincy has shown itself to be for increasingly complex healthcare institutions? Paradoxically, in the breadth of its responsibilities, specialist spiritual care resembles the generalist work of a parish minister. How can the different tasks and sub-roles of healthcare chaplains be combined in such a way that they lead to a strengthening and not a weakening of the profession's profile?

In order that what is distinctive of chaplaincy is not lost in a great variety of activities, certain *non-professional* tasks must be consciously integrated into the primary field of responsibility, which consists, as argued in previous chapters, in a specific contribution to the preventive, rehabilitative, palliative and curative goals of health care. Like other healthcare professionals, chaplains need the ability to switch back and forth between their different sub-roles and domains as appropriate and to respond creatively to the tensions that arise between them. This involves, not least, the capacity to mediate between different forms of spiritual communication and languages.

One of the central insights of recent decades has been that the responsibility of the chaplain cannot be limited to bedside conversations, but also includes an institutional responsibility. Only to the extent that chaplains are involved at the institutional level can they exert a transformative influence in the health institution and, ulti-

275 Amrein, Entwicklung der Spitalseelsorge seit 1960, 26 f.
276 Cf. de Vries, Berlinger, Cadge, Lost in Translation.

mately, avoid being pushed out of it. The coronavirus pandemic has made it bleakly clear what it means when chaplains are shut out of healthcare institutions – and what a difference it can make if they get involved at a systemic level.[277]

Case study: Chaplaincy on the COVID-19 ICU

In March 2020, like teams around the world, the hospital chaplaincy at Zurich University Hospital had to adapt quickly to an emergency. The reports and images arriving from Northern Italy and other regions in crisis were alarming: People suffering from COVID-19 were disappearing into intensive care units to die a lonely death, without chaplaincy support, and without being able to say goodbye to their loved ones. Their bodies were packed in plastic bags without their relatives being able to see them again. They were taken to anonymous morgues until they could be taken in military trucks to a distant crematorium. The urn was often buried in the family's absence, without a religious ceremony, without a blessing.

This shocking situation impelled the healthcare chaplains in Zurich to get involved in preparations for the looming crisis and to try to ensure that good chaplaincy support was available in the newly established intensive care units for COVID-19 patients and that a dignified farewell was possible. The head of chaplaincy Susanna Meyer Kunz remembers: "I approached [...] the doctor responsible for the intensive care unit concerned. What is it actually like when people on this ward die of Covid-19? What provisions have been made for the last goodbyes? He told me: 'Actually, there is no planned farewell. The deceased are put into these body bags. And then there is a farewell at the closed coffin.' Because I kept asking questions, I was ultimately asked to join the interprofessional task force called upon to clarify these organisational issues. How are the relatives informed? What about goodbyes when someone dies? How is chaplaincy involved?"

It was only after a lengthy struggle relatives were ultimately permitted to say goodbye at the deathbed. Even then, this would not have been possible without dogged persistence and an appeal to WHO guidelines,

277 Cf. Szilagyi et al. Chaplain Leadership During COVID-19.

which challenged the myth of highly infectious cadavers from a medical perspective. “In the end, we have developed three scenarios. If up to five people die per day, it is now possible to lay out the body and let relatives say goodbye on the ward. If more die, it would be logistically difficult to maintain a proper standard of dignified support. In that case, we would probably require further external professional support.”

At the beginning of April, the pandemic wave reached Zurich University Hospital. “The doctors and nurses were at their limits, too. There were many resuscitations, and suddenly you realised: this is serious. Until then, I had felt it would probably only affect high-risk patients. But suddenly there were these awful cases. It was frightening. You also realised that ventilation required great care.” Thanks to the clear regulations, chaplaincy support was available to patients in the COVID-19 intensive care ward right from the start. And relatives could also be offered low-level chaplaincy support: “I remember an elderly man whose condition was initially relatively stable, but then deteriorated very quickly. I was in regular contact with his wife. Her biggest concern at first was that she needed her husband’s mobile phone to pay the bills. There I was able to play a bridging role. I made an appointment with her to hand over the mobile phone. And that’s how we first met. She described to me what she was going through. And then the day came. Her husband’s condition kept deteriorating and we were in regular telephone contact. I also delivered voice messages from her and from friends, as I had been doing regularly. On one occasion she also wanted me to recite Psalm 23. She belonged to the Reformed Church, while her husband had left the church and had no religious affiliation. Then she had to be told over the phone that his organs were failing, that they would have to stop the treatment, that her husband was dying. It was challenging for her to decide whether she wanted to come or not, and we spoke on the phone several times and I encouraged her to come. Finally, she decided to come, and was very glad afterwards that she did. Then we went in. She had never been there before, of course. As with other relatives, I helped her put on the protective gown and went with her to her husband’s bedside. She was able to touch him there, which I had never done myself. I can still hear the nurses apologising because they had no candles.

At her husband’s deathbed, the woman talked about their experiences together. The sons, who live abroad, were also able to join us

> remotely. So, they were able to say goodbye to their father. They didn't particularly want religious rituals, but they wanted a prayer. As she had previously told me that her husband loved the music of Reinhard Mey, I intuitively suggested that we could sing 'Above the clouds, freedom must be boundless'. Two residents sang along. It was a very intense atmosphere."
>
> Regarding the significance of the experiences of recent months for the future of hospital chaplaincy, the Reformed chaplain said: "It has become apparent that in some care homes chaplains [...] have become uninvited guests. Guests can be asked to leave. For me, that is the central question that needs to be addressed: Should we be part of the healthcare team? Or is our place outside? This question must also be addressed by the churches. There also needs to be an understanding of chaplaincy contingency plans, something that has also become apparent during this crisis. I was very, very glad that I had a procedure that I could draw on, because all the other professions also inserted theirs into these guidelines."[278]

In their "prophetic" mission to counter the dehumanising tendencies of institutions that are often cash-strapped and dominated by biomedical thinking, chaplains can only be effective to the extent that they are perceived as a serious profession in the health system. So, does the professionalisation of chaplaincy mean that it must be transformed into a health profession?

Healthcare Chaplaincy: A Health Profession?

Starting in the first half of the twentieth century, there have been many attempts from within healthcare chaplaincy to achieve recognition as a health profession.[279] In the 1970s the US *College of Chaplains,* the predecessor of the Association of Professional Chaplaincy,

278 Peng-Keller/Meyer Kunz, Seelsorge auf der Covid-19-Intensivstation des Universitätsspitals Zürich.

279 Cadge, Healthcare Chaplaincy as a Companion Profession, 47.

considered repositioning healthcare chaplains as "allied health professionals".[280] However, despite efforts to identify chaplaincy as a "companion profession", so far a few countries have awarded it the legal status of a health profession. In any case, wouldn't such a change of status lead to a medicalisation or healthification of spiritual care?

Not at all, according to John Swinton and Ewan Kelly, two Scottish theologians who have made the case for chaplaincy to be described as a "unique and important health and social care profession".[281] Swinton and Kelly see standing up for a holistic understanding of health as one of the proper tasks of chaplaincy. The reluctance to call healthcare chaplaincy a health profession is due to a biomedically narrow understanding of 'health(care)'. If health and healing are understood as multi-faceted and spiritually rich phenomena, then it is not merely legitimate but necessary that healthcare chaplaincy be given the title of healthcare profession. Indeed: "Health and social care without spirituality would be a very lonely, empty and thin place for the sick and the dying."[282] Or, to put it positively:

> "Helping the health care system to recognize the depth and breadth of health and the deep complexities of illness is a major contribution that chaplaincy brings to the health care context. Indeed, it may be that such an approach to health and well-being has the potential to enable chaplaincy to be recognized as a truly valuable health care profession in the deepest and most healing sense of the term."[283]

But must a profession really be recognised as a health profession for its place within the health system to be settled? If one casts a glance at the list of recognised health professions, it is clear that there are professions that play an important role in the health system without themselves being health professions in a strict legal sense, e. g. social

280 Cadge, Healthcare Chaplaincy as a Companion Profession, 49.
281 Swinton/Kelly, Contextual Issues, 175.
282 Swinton/Kelly, Contextual Issues, 177.
283 Swinton/Kelly, Contextual Issues, 184. The health policy context of these statements has been presented above: In the UK, healthcare chaplaincy is part of the public health system (NHS).

work and clinical ethics. Given its profile, chaplaincy would fit well into this group of professions, which are not considered "therapeutic" in a narrow sense, but which make significant contributions to healthcare and its curative, palliative, preventive and rehabilitative endeavours. It may therefore suffice for healthcare chaplaincy to be an independent *profession within the health system.*

At the Intersection of Three Mandates

In her survey of healthcare chaplaincy in Europe, the Flemish theologian Anne Vandenhoeck locates the profession within two fields of tension:

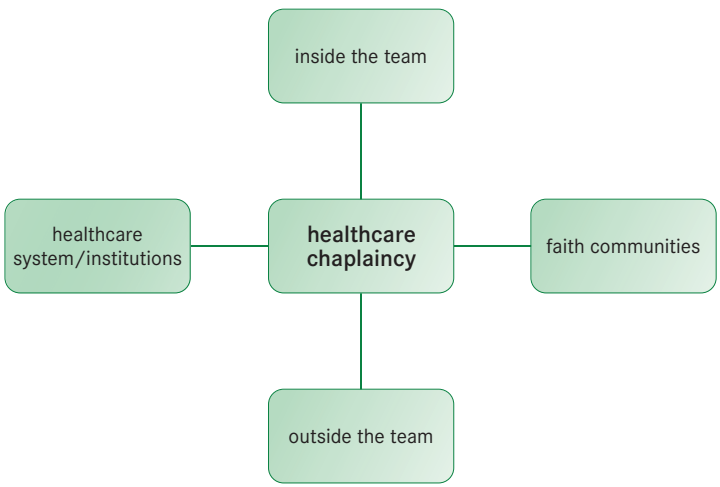

Fig. 6: Healthcare chaplaincy in the midst of tensions[284]

According to Vandenhoeck, chaplains are, on the one hand, specialists in a particular task within the health system and, on the other hand, representatives of faith communities. The question of the com-

284 Vandenhoeck, Chaplains as specialists in spiritual care.

missioning body must be distinguished from that of funding, even though the two are closely related. Even where chaplaincy receives all of its funding from health institutions, chaplains usually have a distinctive position within the organisational hierarchy, which gives them much more leeway than health professionals have. This distinctive position is essentially a matter of chaplaincy's ties with faith communities and the associated legal regulations.

While in some places the ties between chaplaincy and faith communities are currently being loosened or given up completely,[285] Vandenhoeck stresses that the tensions arising from healthcare chaplaincy's dual mandate are constitutive of its role. They should not be resolved but harnessed creatively. In order not to end up in no man's land between faith communities and health institutions, it is necessary to build bridges in both directions. While this first dimension of tension is specific to chaplains, the second, that between integration into care teams and activities that extend beyond them, is also found in (other) health professions. In both respects, the tension manifests itself in questions of priority: How much time and energy should I invest as a chaplain in which people and tasks? Which patients should I see first? How can I deal with divergent needs?

A series of further questions arise from this dual mandate: From which side does healthcare chaplaincy derive its professional ethos? To whom do chaplains report and to whom are they accountable? And what role do intermediary organisations such as chaplains' associations play in the commissioning of healthcare chaplaincy? Are there perhaps more than two commissioning bodies? There's at least one that has not been mentioned yet: the patients themselves and their relatives. The mandate for spiritual care is ultimately theirs. Clarification of the chaplaincy commission is a subtle and gradual process, as many patients visited by chaplains have not considered beforehand whether, and for what reason, they would like to draw on chaplaincy support – indeed, they may at first be surprised by the appearance of a chaplain. There are many factors that influence whether or not someone enters into a conversation and the level at

285 An overview of these developments can be found in Nolan/MacLaren, Religious, Spiritual, Pastoral.

which they are willing to engage. Not least of these is the first impression that chaplains make, through their appearance and communicative presence.

It's helpful to draw on the notion of "initial transference" in this context.[286] In an (initial) encounter, role symbolism and personal experiences combine in a process of transference in which patients and relatives attribute a certain role to the chaplain, which then forms the starting point for any later clarification of the concrete chaplaincy commission. The nature of the mandate must be continually reassessed, especially in cases requiring sustained support over a longer period. It normally takes some time to perceive the deeper needs underlying the concrete concerns.

Case studies: Clarification of mandate

In the preceding case studies, we encountered different ways in which a mandate can be clarified: In the example of chaplaincy in the COVID-19 intensive care unit, the chaplain first takes on the task of handing a mobile phone on to the patient's wife. This initial contact leads to further interactions.[287] The commission and the clarification of the mandate is far more complex for the chaplain on the oncology ward.[288] Here the chaplain gets involved at the request of the nursing team and spends a lot of time and effort finding out what Mrs. L.'s needs are and how he can best address them.

Treating patients and their relatives as the primary clients of healthcare chaplaincy means moving flexibly in the field of tension just outlined, while remaining focused on the addressee. The commissions that healthcare chaplains receive (and sometimes also reject) from patients and their nearest of kin can be very diverse and sometimes contradictory. Chaplains are not always called upon as persons who understand and speak a particular language of faith. But sometimes,

286 Gestrich, Am Krankenbett, 19.
287 Case study: Chaplaincy on the COVID-19 ICU (142–144).
288 Case study: "I have to go home urgently" (125 f.).

even today, this is precisely what is important. The ability to code-switch consciously, mentioned once before, is the communicative competence needed to be able to provide healing chaplaincy support in complex and often ambivalent situations.

A systemic account of healthcare chaplaincy's triple mandate

Taking a systemic perspective approach on healthcare chaplaincy, Christoph Morgenthaler describes it as working "at the intersections of three large types of systems: the hospital as a system with its subsystems, the system of relatives with its subsystems and the church as a system from which the subsystem of hospital chaplaincy has developed."[289] This gives rise to the following concise summary: "Chaplaincy encounters are professionally legitimated and structured encounters within the overlap between these systems."[290] The virtue of this description is that it brings to mind the complexities of what happens in a chaplaincy encounter within the clinical context, allowing the associated ambivalences to be discussed and addressed. This is in line with his plea for chaplaincy to be tolerant of ambivalence: "to be open to the simultaneity of opposing emotional tendencies in individuals, in the systems of relatives and in the hospital system, yes, to be an advocate for ambivalence [...], without reducing complexity, but concerned with God as 'complexio oppositorum'".[291]

The challenges that arise from healthcare chaplaincy's triple mandate are particularly felt in three areas: in questions to do with interprofessional collaboration, in ethical issues, and in inter- and trans-religious constellations. The following sections address these topics in turn.

289 Morgenthaler, Systemische Seelsorge, 287.
290 Morgenthaler, Systemische Seelsorge, 289.
291 Morgenthaler, Systemische Seelsorge, 293.

Cumulative Complexity and Interprofessional Collaboration

The more specialised medicine and the more complex health organisations become, the more urgent the need for interprofessional cooperation and integrative approaches to care. As specialised spiritual care, healthcare chaplaincy helps health professionals take account of "the deep complexities of illness"[292] and the multidimensionality of health. For this to happen, chaplaincy must be integrated interprofessionally and understood as part of the care concept. The following sections outline how these framework preconditions can be conceived.

The "Cumulative Complexity Model"

To substantiate its contribution to curative, palliative, rehabilitative and preventive tasks, chaplaincy must draw on recognised models of care that are not limited to the biomedical dimension. The "cumulative complexity model", developed by Victor M. Montori together with a research group at the Mayo Clinic in Rochester, offers a previously untapped basis for doing so.[293] This model operationalises the biopsychosocial model of health with regard to people with chronic disease. It focuses in particular on the complex feedback effects that result from the interplay of different stress and efficacy factors. Complexity is defined as "a dynamic state in which the personal, social, and clinical aspects of the patient's experience operate as complicating factors."[294]

The central ideas of this model are largely uncontroversial. The first is the observation that people with chronic disease have a double burden to bear: the disease itself, but also the strains of the therapeutic measures. The latter includes not only the side effects of invasive therapies, but also, for example, the organisational workload involved (e. g. travel to the hospital), which is often difficult to fit in alongside professional and family commitments.

292 Swinton/Kelly, Contextual Issues, 184.
293 Shippee et al., Cumulative complexity.
294 Shippee et al., Cumulative complexity, 1041.

The second central idea emphasised by the model is that those affected by chronic disease themselves make a significant contribution to the therapy.[295] Their role is not limited to that of a patient, but also includes co-therapeutic elements (the authors speak of self-care). The third central idea is that the extent to which offers of therapy are accepted and effective depends essentially on whether the people concerned have sufficient internal and external resources at their disposal to be able to face the burdens of illness and treatment (which often aggravate problems that are independent of the illness, such as unemployment, family difficulties, etc.).

In the words of the authors, it is a matter of "the balance between patient workload of demands and patient capacity to address demands. Workload encompasses the demands on the patient's time and energy, including demands of treatment, self-care, and life in general. Capacity concerns ability to handle work (e. g., functional morbidity, financial/social resources, literacy)."[296] If the stress factors accumulate such that the patient can no longer cope, negative feedback effects set in. If all goes well, there is a process of adaptation in which patients gradually learn to integrate illness- and therapy-related stresses into their everyday lives, and draw on additional personal resources and external support.

One strength of the *cumulative complexity model* is that it brings together the many factors that contribute to or undermine therapeutic effectiveness. It does this in a way that corresponds to the aspirations of contemporary healthcare and that allows the contribution of chaplaincy to therapeutic processes to be determined more precisely. This contribution can be determined in three ways, on this model: With their expertise in the psychosocial field, especially regarding religious and spiritual support and stress factors, chaplains can contribute *first* to strengthening the personal and social resources of patients and relatives, *second* to reducing the stress caused by illness or therapy, and *third* to helping patients play a part in the therapeutic process. In highly complex illness situations, chaplains' supportive contribution (as well as that of social work, ethics counselling, etc.)

295 There are points of contact here with recovery models.
296 Shippee et al., Cumulative complexity, 1041.

should not be regarded as a supplement to normal care, but as an integral part of an interprofessional care model. This leads us to the next topic.

From Multiprofessionalism to Interprofessionalism

Although the 20th century CPE emerged from an *inter*professional experiment, as outlined above, cooperation between chaplains and health professionals has so far largely been based on a multiprofessional model, which provides for proper coordination of activities but not for intensive cooperation.[297] Within the health system, there has been a growing awareness that while this multiprofessional approach accommodates the desires of individual professions for autonomy and domains of authority, it is inadequate in a highly specialised clinical world. The more complex a disease, the more specialists and teams are involved, so that the challenge is not simply to work together in a single interprofessional team, but to coordinate "multi-team systems".[298]

To ensure continuity of care under such conditions, clearly structured interprofessional cooperation is needed. Empirical studies highlight the importance of interprofessional cooperation: It "contributes to safe, effective, and efficient patient care. […] teamwork has been proven to positively influence performance outcomes, including clinical performance, supervisor ratings, and patient satisfaction".[299] Not least, teamwork has a positive effect on "well-being, engagement, and job satisfaction".[300]

The WHO defined interprofessionalism as "when two or more individuals from different backgrounds with complementary skills interact to create a shared understanding that none had previously possessed or could have come to on their own. When health workers collaborate together, something is there that was not there

297 Unfortunately, this distinction is not yet widely established in the international research literature, cf. Bleakley et al., Improving teamwork climate in operating theatres.

298 Ingels et al., Interprofessional teamwork in healthcare.

299 Ibd. 338.

300 Ibd.

before."[301] It is only just beginning to become clear what it would mean for spiritual care to develop from multiprofessionalism to interprofessionalism. If interprofessional cooperation involves "shared responsibility, and shared decision making in the aim of achieving a shared goal",[302] what does this look like in the field of spiritual care? Who guarantees the continuity of spiritual care in "multi-team systems"? Where and in what way does mutual exchange take place? At present, at least four central forms can be identified: interprofessional meetings, ethical case conferences, professional development, and clinical documentation. The last of these might at first appear to be of secondary importance, but on closer examination it proves to be a hinge point where the developments described earlier are particularly evident. I will therefore concentrate on this topic.

Digital Documentation of Interprofessional Spiritual Care

The developmental trends and problems described in previous chapters come together in the interprofessional documentation of spiritual care in digital patient records, with the addition of a further factor: the digitalisation of society and healthcare. In today's highly complex health institutions, internal communication and cooperation increasingly takes place on electronic hospital IT systems. Sooner or later, chaplains will have to participate in this form of communication and document their work digitally. As we saw in the example from Nairobi, this development is not limited to western countries and university hospitals.

Excursus: Healthcare Chaplaincy Documentation at the Outset of CPE

The idea that healthcare chaplains should document their work for the purposes of interprofessional collaboration is by no means new. It can already be found at the outset of the CPE. In their 1908 book, Elwood

301 WHO, Framework for Action on Interprofessional Education & Collaborative Practice, 36.

302 Ingels et al., Interprofessional teamwork in healthcare, 340.

> Worcester, Richard Cabot and Isador Coriat mention a documentation practice of this kind, which had emerged within the framework of the Emmanuel Movement.[303] These early impulses later fed into *Clinical Pastoral Education,* co-founded by Cabot in 1925. Together with the Protestant theologian Russell L. Dicks, Cabot published a foundational work on healthcare chaplaincy in 1936, which contains a comprehensive chapter on pastoral documentation.[304]

The increase in the obligations on those working in the health system to provide documentation is clearly an ambivalent development. Couldn't the time used for documentation have been used for other things? And if chaplaincy starts to contribute to this interprofessional documentation, won't it get caught up in these ambivalences? It will undoubtedly lose some of the "incredible independence"[305] that it has enjoyed in recent decades.

Documentation gives rise to (greater) transparency. It reveals what chaplains are doing, where they are involved and where they are not. This makes them more vulnerable to criticism and reproach, but it also makes their work more visible. It becomes more apparent what they contribute to the alleviation of suffering and to the improvement of the quality of life of the sick, the dying and the grieving, and how they "strengthen the power to be human".[306] In this way, healthcare chaplaincy takes responsibility for its actions. And that is a good thing. It does not have to hide. Through their ministry, chaplains contribute to the overall mission of the health institution in which they work.

The central challenges associated with current changes in healthcare chaplaincy are thus revealed under the magnifying glass of the digital charting. Documenting one's own chaplaincy work in a way that strengthens interprofessional collaboration while protecting

303 Cf. Worcester/McComb/Coriat, Religion and medicine, 6.
304 Cf. Cabot/Dicks, The art of ministering to the sick, 244–261.
305 Spoerri, Spitalseelsorge als Anachronismus, 143.
306 This is the programmatic title of the 2004 EKD guidelines for Protestant hospital chaplaincy.

confidential information is an art form that requires training and supervision. For this reason, North American CPE training programmes are placing a greater emphasis on gaining expertise in documentation. To get an impression of the new documentation practice, let us consider an example in detail.

The digital documentation of healthcare chaplaincy in Québec

In chapter two we saw how various factors led to the 2010 transfer of responsibility for healthcare chaplaincy in Québec to health care institutions, which are now legally obliged to attend to the spiritual needs of their patients. Following this development, healthcare chaplains must now document their work. A working group of experienced chaplains was commissioned to develop a suitable instrument with which chaplains could document their work in a way that meets chaplaincy objectives.[307]

The instrument was developed in three phases: First, a pilot model was designed on the basis of experience and a literature review. In the second phase, the resulting model was used on a trial basis in everyday clinical practice. A revised version of the instrument was then validated in the third phase. The aim was to develop a flexible tool that is able to apprehend spiritual concerns, and which facilitates and standardises chaplaincy documentation. Significantly, the working and research group took inspiration from the Christian anthropology of Michel Fromaget, which is characterised by the classical distinction between body, soul (âme) and spirit (esprit).

The spiritual dimension is conceived in anthropological terms and distinguished conceptually from the psychological dimension. The content of this dimension is characterised, on the one hand, by reference to life-encompassing meaning, and on the other by experiences of transcendence, which provide meaning in the face of illness, dying and death: "We recognize three main paths which can lead to a transcendent experience: the emotion of love, wonder in the face of beauty and a third, which is crucial in the field of health: the crisis or approach of death."[308]

307 For further details on the following, see Bélanger et al., The Quebec model of recording Spiritual Care.

308 Bélanger et al., The Quebec model of recording Spiritual Care, 59.

Finally, the model connects experiences of meaning and transcendence to four fields of reference within which such experiences can be found: significant relationships; values and commitments; beliefs and practices; and hopes. The dynamic interlacing of these areas of experience is displayed in the following illustration, which also serves as an aid to memory and perception:

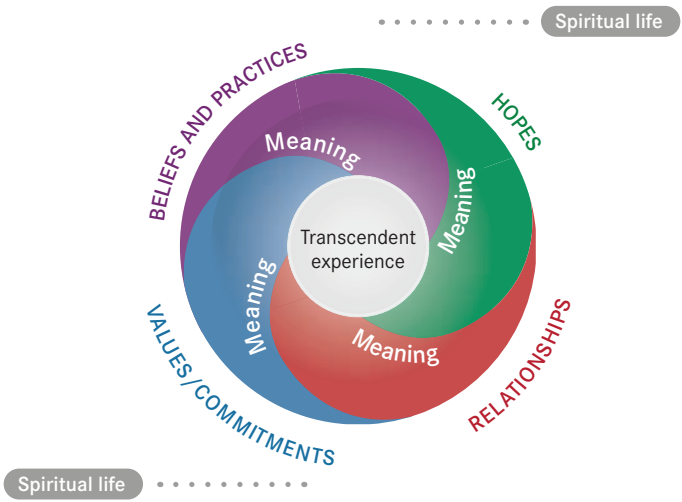

Fig. 7: Markers for spiritual care documentation in Québec. The experience of transcendence, which is located in the centre, is mediated through various areas of meaning.

It is significant that, in this illustration, the experience of transcendence is the organising centre of the four highlighted meaning-giving areas of life. In this way, the instrument makes it clear what differentiates chaplaincy from psycho-social care, which in its own way also deals with relationships, values, beliefs and hopes: the difference is chaplaincy's orientation towards religious and non-religious transcendence. With regard to the therapeutic dimension of healthcare chaplaincy, one could say that chaplaincy care, on this model, is focussed on the healing power that is due to explicit or implicit experiences of transcendence. The documentation instrument is based on this model and covers the following areas:

1. Context of assessment/intervention
   - 1.1 Reason for meeting
   - 1.2 Patient's condition
   - 1.3 Sociodemographic data
2. Exploring markers
   - 2.1 Beliefs/practices
   - 2.2 Hopes
   - 2.3 Relationships
   - 2.4 Values/activities
   - 2.5 Transcendent experience shared by the user
3. Professional analysis/opinion
   - 3.1 Identification of a support marker and an obstacle marker in the user's path
   - 3.2 Summary and professional opinion based on analysis model
4. Intervention conducted (where appropriate)
   - 4.1 Results
5. Follow up and support plan
   - 5.1 Follow up
   - 5.2 Support plan
6. Consent to care

The differentiation and clarity of the Canadian documentation instrument are impressive. But does chaplaincy confidentiality receive sufficient protection? Or, more generally, how can interprofessional (and *intra*professional) documentation practices with digital media ensure that chaplaincy confidentiality is maintained? To answer this question, it is necessary to take into account conceptual, legal and organisational issues. The following key points should be mentioned in this regard:[309]

(1) Where chaplains contribute to documentation there need to be clear guidelines as to what should be documented and for whom.

(2) Documentation can be more or less comprehensive. Minimal documentation is limited to organisational essentials, such as which chaplains are involved and what further action is planned.

309 See also Vandenhoeck et al, Charting by Chaplains in Healthcare.

(3) If chaplaincy documentation is also meant to introduce chaplaincy's spiritual perspective into interprofessional cooperation, it cannot be limited to organisational matters. For the purposes of interprofessional spiritual care, it is helpful if chaplains document what they perceive and do. They can record their assessments without revealing the content of their conversations.

(4) Chaplaincy documentation can take two fundamentally different forms: entries can be written freely in the chaplain's own words; or they can be framed using broad, predefined keywords, describing the results of assessments or interventions. Both forms have their advantages and disadvantages. While freely formulated entries tend to be more reader-friendly and informative, it is easier to maintain chaplaincy confidentiality with standardised formulations.

(5) From a theological point of view, the confidentiality of chaplaincy must be distinguished from the confessional secret.[310] Not every chaplaincy conversation is a confession. In health contexts, such conversations are the exception rather than the rule, and so should not be considered paradigmatic.

(6) Chaplaincy confidentiality is the chaplain's form of professional confidentiality. It is related to the professional identity and ethos of chaplaincy. The confessional secret, however, is linked to a specific chaplaincy task and is thus a special case of the chaplaincy confidentiality.

(7) Interprofessional cooperation in the health system requires shared professional confidentiality. Without this, a high standard of care cannot be guaranteed. However, even among health professions, shared professional confidentiality does not mean that all information is shared freely between the professions involved.

(8) Whether and to what degree chaplains can participate in this shared professional confidentiality is a matter for both chaplains and health professionals. In many European countries and institutions, for example, chaplains have no access, or only a limited right

310 Moos et al. show that this distinction is not only significant for Catholic chaplaincy and chaplaincy practice, but also for chaplaincy research: Ethik in der Klinikseelsorge, 26.

of access, to patient files and they limit their notes to elementary information, if they document at all.

(9) The legitimacy and necessity of chaplaincy involvement in interprofessional communication and documentation depends on whether healthcare chaplaincy is considered to be a profession that contributes to regular healthcare, or to be an independent and external service. In the first case, chaplaincy documentation is a necessary for quality assurance, while in the second case it is only legitimate to the extend it is needed for organisational coordination.

(10) Interprofessional documentation in electronic patient records is increasingly influenced by the fact that more and more patients are taking advantage of the possibility of inspecting their files. Documentation is therefore becoming a form of indirect communication with patients. This gives rise to the rule that documentation should be written in such a way that those concerned would feel they have been understood and taken seriously, should they read the documentation afterwards.

Chaplaincy in the Field of Clinical Ethics

The challenges that arise in the context of the interprofessional integration of chaplaincy are particularly delicate in the field of clinical ethics. In view of the growing need for guidance and counselling in this conflict-ridden field, the discernible trend towards greater involvement of chaplains in this area is perhaps not surprising. For instance, in the study published in 2015 by Massey et al., one of the most frequently mentioned chaplaincy activities was "align care plan with patient's values".[311]

In historical terms, however, such involvement was not a matter of course. On the one hand, in the 1970s, clinical ethics defined itself in opposition to religiously inspired ethical models.[312] On the other hand, CPE had already abandoned the notion that chaplains should directly address the patients' morals when it adopted the Rogerian model of non-directive counselling during the Second World War.

311 Massey et al., What do I do, 4.
312 Kim et al., Back to the future.

There was a concern not to confront suffering people with norms, but to make them feel unconditionally accepted.

As shown by the example of Steve Nolan cited above, chaplains can perform this task effectively, even when they are inevitably perceived as representatives of moral norms and expectations. In chaplaincy conversations marked by compassionate presence, entrenched expectations can be effectively undermined by recalling the limits of moral judgement. The relativisation of moral questions is integral to the ethos of contemporary healthcare chaplaincy: "It is not our moral capacity that is the pinnacle of our humanity, but our need for salvation. It is the task of hospital chaplains to show this again and again, through simple presence and compassion, through words and signs."[313]

Participation in ethics counselling within shared decision-making processes is one of the new fields of healthcare chaplaincy activity that have grown since the 1990s. This development is an international one, as shown by the studies cited below. In Germany this process was accelerated by the commitment Protestant and Catholic hospital associations made, as early as 1997, to implementing ethics counselling on the US model.[314]

This development undoubtedly favours the stronger integration of chaplains into the health professional field – or, put another way: Healthcare chaplaincy can only dedicate itself to this new field of activity to the extent that it is prepared to commit to engaging with institutional processes. As with documentation, this development forces chaplaincy to clarify its self-understanding, its position, its (self-)obligations and dependencies. To this end, it is necessary to establish in what sort of situations chaplains are being involved or are actively involving themselves in ethical counselling, and what form this involvement takes. Several recent empirical studies can shed light on this.

313 Zimmermann, Bioethik und Spitalseelsorge, 53 f.

314 Deutscher Evangelischer Krankenhausverband/Katholischer Krankenhausverband Deutschlands, Ethik-Komitee, 5.

Empirical studies on chaplaincy and clinical ethics

The most comprehensive study to date of the role of chaplaincy within interprofessional Shared Decision Making (SDM) was conducted by a research team led by Jeanne Wirpsa and involved a qualitative and quantitative survey of 463 US chaplains. 38 % of the respondents said they often participated in such interprofessional decision-making processes. The chaplains considered their role to involve pointing out the significance of religious and spiritual factors for the decisions to be made, exploring patients' personal values and acting as mediators between patients, relatives and treatment teams.[315]

According to the study, the following factors complicate the inclusion of chaplaincy in SDM: "Systems/Staffing (25 %), Timing of Referrals (24 %), Understanding of Chaplain Role by Other Members of the Team (14 %), Interdisciplinary Team Dynamics and Role Definitions (13 %), Patient/Family Barriers (5 %), Barriers Internal to Chaplain (5 %)".[316] While the first two factors are organisational, all the others have to do with the external and internal understanding of the role and competencies of chaplaincy: "The persistence of a biomedical model of care was highlighted by chaplains in our study as a central reason for the lack of chaplain inclusion in SDM. As one chaplain observes: 'Practitioners who strongly emphasise the medical evidence of the decision-making process over the emotional and spiritual components are less likely to utilize chaplaincy services.'"[317]

An increase in the involvement of chaplains in the field of clinical ethics was also found by two studies conducted in Germany. The first study, conducted at the *Forschungsstätte der Evangelischen Studiengemeinschaft* (FEST) in Heidelberg, asked 32 chaplains about their work in the field of ethics and the challenges involved.[318] It became clear, first of all, that chaplains' work in this area is not limited to clinical-ethical decision-making situations. Ethical questions are also raised by the

315 Wirpsa et al., Interprofessional Models for Shared Decision Making. See also the case studies by Wirpsa/Pugliese based on this survey, Chaplains as Partners in Medical Decision-Making.

316 Wirpsa et al., Interprofessional Models for Shared Decision Making, 35.

317 Ibd. 36.

318 Moos et al., Ethik in der Klinikseelsorge.

organisational culture and by ritual practices. Nevertheless, chaplains are most frequently brought in to help with ethical issues in connection with medical decisions at the beginning and end of life. In such cases, however, they did not only provide support during decision-making processes, but also helped those involved, including the treatment teams, deal with subsequent issues.

In the second study, which was conducted by the department *Medizinethik in der Klinikseelsorge* at Goethe University Frankfurt, 19 chaplains were asked about their experiences in the field of ethics.[319] The results are largely in line with those of the FEST study. The chaplains interviewed point to the dominance of the medical perspective as well as to the tension between their chaplaincy and medical ethics roles. This tension is partly the result of external factors – such as the particular expectations, beliefs and prejudices that people have regarding the role of chaplaincy – but partly also represents an internal conflict.

The church mandate can act as constraint on medical ethical tasks. According to the interviewees, if chaplains are only partially integrated into the institution, they may have limited access to information, which makes it more difficult for them to exert influence. At the same time, they point to situations in which chaplains are themselves active in organisational development. Finally, the study points out that chaplaincy can only hope to receive recognition in the medical field to the extent that it is able to demonstrate competences. The study concludes: "In order for healthcare chaplains to be able to fulfil these roles in medical ethics and organisational ethics, they need to be given recognition not only in the hospital context, but also by their churches. Churches must make clear their commitment to the role of the healthcare chaplain as an actor in medical ethics, with all the resources that this requires."[320]

319 Mandry/Sperneac-Wolfer/Wanderer, Klinikseelsorgerinnen und Klinikseelsorger als medizinethische Akteure.

320 Mandry/Sperneac-Wolfer/Wanderer, Klinikseelsorgerinnen und Klinikseelsorger als medizinethische Akteure, 17.

The Professional Ethics of Healthcare Chaplaincy: A commitment to therapeutic professionalism

For healthcare chaplains, ethical questions do not only arise in their encounters with patients facing hard choices; they also face an ethical question themselves: What does it mean to be a good healthcare chaplain? Peter Sedgwick investigates this question in a discussion of chaplaincy and ethics.[321] The question concerns both the professional ethics of chaplains and the criteria by which the quality of chaplaincy work is to be evaluated. Sedgwick focuses on the first aspect and contends that chaplains are responsible to a double ethical framework: that of the institution for which they work, and that of their religious community.

This double obligation can give rise to tensions in everyday healthcare chaplaincy. For example, when confronted with the question what form of spiritual care should be offered in a case of assisted suicide. However, tensions between different professional obligations and between institutional and personal value systems are not unique to healthcare chaplaincy, but occur in the medical, nursing and psychotherapeutic professions as well.[322] Ethical competence therefore involves being able to deal with such tensions in a reflective way as well.

A professional ethics for healthcare chaplaincy must also include a commitment to therapeutic professionalism. While chaplaincy aims to do good, it may nevertheless sometimes have adverse effects. For this reason, it is subject, in clinical contexts, to the globally applicable principles of medical ethics, those of non-maleficence and beneficence, as well as to that of patient autonomy.[323] This means that chaplains are not only required to carry out their work with all due diligence but must also be able to demonstrate that they are supporting patients in an effective way. This much should be obvious: Chaplains must not fall short of the ethical and professional standards that apply in health institutions.[324] The duty of therapeutic vigilance, critical self-examination and self-restraint is all the more cru-

321 Sedgwick, Chaplaincy and Ethics.

322 Mohrmann, Ethical Grounding for a Profession of Hospital Chaplaincy, 20 gives the example the tension between the physician's obligation to be patient-oriented and that of training future professionals.

323 Beauchamp/Childress, Principles of Biomedical Ethics.

324 Peeters, Quality Pastoral Relationships in Healthcare Settings.

cial because the churches have squandered the trust placed in them through amateurish and intrusive chaplaincy in recent decades. A 2004 document published by the Evangelical Church of Germany (EKD) clearly expresses this desideratum:

> "It is enormously helpful for the healthcare chaplains themselves if they systematically raise the matter of the essential processes and structures of their professional and economic organisation, align themselves with their goals, test their character against the yardstick of these goals and dedicate themselves to continuous quality improvement on the basis of the results. In this way, it is possible to learn from experience in a sustainable and imaginative way and to shape social reality. Actions are not changed as a result of abstractly changing mindsets first; rather, mindsets are broadened as a result of an attentive and careful approach to action. The initiative in this regard should lie with the individual healthcare chaplain."[325]

According to Margaret Moormann, healthcare chaplaincy is subject to an "ethic of accountability". Chaplains must give an account of their actions and objectives, of the criteria by which good chaplaincy care can be assessed and how binding quality assurance is to be conducted.[326] If this is done according to the standards of the healthcare system, there will be three important consequences:

1. *Evidence-based chaplaincy:* Chaplains working in healthcare cannot simply assume that their services (and they themselves) are good for the people they are attending; this is something they must be able to demonstrate. They must also be prepared to ground their actions in the current state of knowledge and to allow themselves to be guided by new evidence.[327] Professional healthcare chaplaincy presupposes chaplaincy research into the most effective forms of chaplaincy care for each context.

325 EKD, Die Kraft zum Menschsein stärken, 32.
326 Mohrmann, Ethical Grounding for a Profession of Hospital Chaplaincy, 20.
327 Grossoehme, The Role of Science in Enhancing Spiritual Care Practice, 99 f.

2. *Evidence-based chaplaincy training:* The same is true of chaplaincy training. In order to lend credibility to the message they represent and to uphold the fundamental ethical principles and professional standards of healthcare, trainee chaplains must familiarize themselves with empirically based models of chaplaincy care and learn to exercise critical self-examination. The form of healthcare chaplaincy training developed during the previous century was aimed at instilling this kind of professionalism. It must now be developed further to suit changed circumstances.
3. *Quality management:* For the reasons just given, healthcare chaplaincy work will in future have to undergo a more intensive form of quality management than has so far been the case. Chaplains would do well proactively to develop the tools for this themselves. In particular, this will involve creating suitable documentation instruments, since quality management is not possible without accurate and transparent documentation of chaplaincy activities.[328]

Ethics Counselling and the Chaplaincy Mandate

There are many ways in which healthcare chaplains are involved in clinical ethics: whether directly with patients and their relatives in often fluid situations, or in an institutionalised way in interprofessional discussions and clinical ethics committees. Many questions need clarification in this regard: What is the relationship between ethics counselling and spiritual care? Which models can chaplains use to guide them in this new task? And what are the criteria by which good healthcare chaplaincy in this field is judged?

With regard to the topic of this book, the following can be stated, without going into too much detail at this point: The growing involvement of chaplains in therapy decisions is a further indication that healthcare chaplaincy is increasingly established as a profession within the healthcare system; a profession which, in its own way and through interprofessional cooperation, contributes to the achievement of the healthcare system's goals." Given the expectation that

328 An alternative is to interview patients, see Snowden/Telfer, The Story of the Scottish Patient Reported Outcome Measure.

chaplains must surely know about ethics, the professional profile of healthcare chaplaincy is changing."[329]

There is general agreement that healthcare chaplains take on a distinctive role when they offer ethics counselling, and that they must be careful not to confuse this with their other roles. Finally, there is a consensus in the literature that there is a need for additional chaplaincy qualifications in this area, given the complexity of medical ethics decisions. Healthcare chaplains cannot do everything, and certainly not everything at once. Therefore, they have continually to clarify the role in which they are working or being asked to work and the skills they need for the task at hand. In general, it can be assumed that a similar basic ethical competence can be expected from healthcare chaplains as from related counselling professionals. On the one hand, this includes familiarity with the concepts and practice of medical ethics; and on the other hand, the ability to identify and articulate the moral issues of everyday life, to reflect on one's own positions, to refine them and to advocate them.[330]

Even when healthcare chaplains are working in an explicitly advisory capacity, for example in an ethical case discussion, they have a dual role. On the one hand, they are clinical experts on religious and spiritual affairs, and, on the other hand, they are representatives of a particular religious ethos: "The chaplain can act neither as a medium (mirror) nor as an impartial observer but is involved as a representative."[331] The specific contribution of chaplaincy to clinical ethics counselling is to be found precisely in this dual role. What chaplains provide is not just theological and ethical expertise, but the perspective of a particular faith tradition that will be shared by at least some of the patients and health professionals working in the institution. In the guidelines for healthcare chaplaincy work in the field of medical ethics, published by the US *Association of Professional Chaplains* in 2000, this dual role – as expert and representative – is captured in formulations such as the following: "The Chaplain serves as an advocate for the spiritual values and religious

329 Moos, Ethik als Herausforderung der Klinikseelsorge, 605.
330 Welfel, Ethics in Counseling.
331 Körtner, Seelsorge und Ethik, 100.

beliefs held by the patient, even when those values and beliefs are not those of the Chaplain."[332]

If those involved in a case are to be able to make this distinction, it must be clear to them which values the chaplain represents. Just as transparency regarding any vested interests is an essential aspect of contemporary research ethics, it is one of the basic ethical standards for healthcare chaplains that they are prepared to declare their values and the spiritual tradition to which they are committed. This leads us to the next and final topic of this chapter.

Chaplaincy in Inter- and Transreligious Constellations

In societies that are increasingly characterised by cultural, ideological, religious and spiritual plurality, a high degree of intercultural and interreligious competence is demanded of chaplains. It is increasingly normal for chaplains to find themselves in multi- and transreligious constellations. Against this background, the central idea of this book, that healthcare chaplaincy should be understood as a specialised form of spiritual care, must be made more precise. Two things need to be emphasised here. Firstly: As specialist professionals who know their way around the multifaceted world of religions and spiritualities in today's pluralist societies, healthcare chaplains increasingly have an educational role and are often called upon to give advice and mediate in decision-making and conflict situations. In this way, they can make a significant contribution to culturally sensitive care.

On the other hand: Every specialisation has its limits – and this is certainly true in the field of spiritual care. Even the most comprehensively trained healthcare chaplains have their areas of specialisation and cannot be equally familiar with *all* traditions, questions and practices of lived spirituality. This limitation is not merely a matter of the complexity and plurality of contemporary spirituality and personal boundaries but relates to something much more fundamental: the positionality and embedding of the chaplains themselves. They

332 Association of Professional Chaplains, Guidelines for the Chaplain's Role in health care Ethics, 2 (Guideline III,3).

do not embody the view from nowhere: each has a particular perspective, has followed an individual spiritual path and belongs to a particular culture[333] and faith community, although these affiliations – like that to one's own family – may be stronger or weaker and may be strained. It is precisely chaplains' commitment to specific traditions that makes certain forms of chaplaincy communication possible: the spontaneous formulation of a Christian or Muslim prayer, a particular interpretational perspective, an act of baptism, ritual cleansing etc.

Belonging to a particular faith community, which chaplains symbolise (in different ways), brings with it its own limitations. This is particularly clear in that case of rituals, such as the Catholic anointing of the sick or confession, but it is true of chaplaincy communication in general. The idea of a non-denominational form of specialised spiritual care is a late-modern chimera – or a strategy to conceal the particularity of one's own perspective behind the guise of apparent universality and non-denominationalism. Humanist chaplains are likewise limited in this way, committed to a humanist credo and aspiring to represent a particular segment of the population.

Since the diversity of religious and spiritual identities affects not only the patients and their relatives, but also the chaplains themselves, this can result in complex settings. The official and personal positionalities of chaplains give rise to various educational and organisational duties, at both institutional and national levels, and to a variety of inter- and transreligious constellations. Some of these are harmonious, while others may be fraught with tension. In the second chapter, we saw how some country-specific models have responded to the growing religious and spiritual diversity on different levels: on the macro-level, through new legislation and the restructuring of chaplaincy organisations; on the meso-level, through a diversification of chaplaincy teams (e. g. in England) or the introduction of a 'generic chaplaincy' (e. g. in Scotland); on the micro-level, through adaptive communication strategies (e. g. code-switching).

333 For this reason, Western concepts of spirituality are sometimes difficult to comprehend from a Chinese perspective, cf. Kwan, Negotiating the meaning of spirituality.

The integration of a non-denominational section within the *Association of Spiritual Caregivers in the Netherlands* is particularly instructive in this context, because it brings into sharp relief the unresolved problems that are engendered by current developments. What distinguishes the Dutch chaplains of this section from their colleagues in the others is not that they are not themselves guided by their convictions and influenced by particular traditions, but that their convictions prevent them from identifying with any of the other sections. What is remarkable about the Dutch developments is that non-denominational chaplains are also required to have a hermeneutical and spiritual competence, which presupposes a particular spiritual perspective of their own. How such a competence can be adequately evaluated, however, is still unclear.[334]

Various forms of inter- and transreligious chaplaincy are possible within the framework of a self-critical positionality, and many have been tried in practice. I will take a look at two instructive case reports from Germany by the Protestant chaplain Ulrike Mummenhoff:

Case study: The triple blessing

"I have three chaplaincy encounters in one morning with three Christian old ladies in a four-bed room. Two are Protestant, one Catholic. All three conversations are marked by sadness and tears. One of the ladies asks me for communion the next day and the other two decide to join in. A Muslim woman is sitting on the fourth bed. I also go to her, offer her my hand and, as she does not speak German, we are unfortunately only able to exchange our names. Nevertheless, the connection is very warm. The next day I come to give the communion service. I welcome all four and organise the communion. At the end of the celebration, I lay my hands on the three participants and bless them. When I look to the Muslim lady, she waves me over, nods and bows her head: she also wants to receive a blessing. I bless her. A few days later she is discharged. I meet her in the corridor accompanied by her son. She takes me in her arms, blesses me and says something

334 ten Napel-Roos et al., Non-Denominational Spiritual Care Givers.

> to her son, who relays to me: 'My mother says you are a good woman and wishes you Allah's peace.'"[335]

In this case report, there is a twofold expansion of chaplaincy care. First, there is an ecumenical opening: in conversation initially, then in the Protestant communion service, in which the Catholic patient also takes part. The second opening was initiated by the Muslim patient, who was a silent witness to the tearful counselling sessions. There is a first cordial, relationship-building contact. This prepares the ground for the next step.

The next day, the constellation is repeated, with the three Christian patients and the pastor now forming a communion congregation. The Muslim patient respectfully stays in the background but takes the initiative after the final blessing. Even though she does not understand the words, she knows from her own religious tradition what it is to be blessed. Using gestures, she asks the Protestant minister for her blessing. This gives the minister a chaplaincy mandate that goes beyond that of her church. How did she feel about this?

The commentary on the case report reads: "I was surprised at first by her wish for a blessing. At the same time, I realised that it was an expression of what we had experienced together, and I was happy to bless her."[336] The chaplain notices that the Muslim patient witnesses the communion service. She is part of the community of solidarity in this hospital room and ultimately of the shared celebration. God's blessing brings people together. And in the end, the chaplain herself also receives a transreligious blessing. She feels "that the Muslim woman's blessing was heartfelt and was meant for me as a person and a human being, and I gladly accepted it".[337] The blessing transcends linguistic and religious boundaries and is a tangible expression of the fact that chaplaincy is a responsive process in which the givers are themselves receivers.

335 Mummenhoff, Interreligiöse Seelsorge im Arbeitsfeld Krankenhaus, 245 f.
336 Mummenhoff, Interreligiöse Seelsorge im Arbeitsfeld Krankenhaus, 246.
337 Mummenhoff, Interreligiöse Seelsorge im Arbeitsfeld Krankenhaus.

Case study: Interreligious constellations in the family

In another case study, Ulrike Mummenhoff describes the support provided to a family from Asia. The father is seriously ill and is receiving palliative care. He is Catholic and is also being supported by an external priest, who comes from the same country. After talking with the man and his wife and daughter, the chaplain offers to say a prayer with the man, which he hesitantly accepts. The atmosphere during their conversation is strained. In a later conversation with the daughter, the chaplain learns that the mother is Buddhist and a second daughter is also inclined towards Buddhism, while the son is non-religious and a son-in-law is Muslim.

In further talks with the mother, it becomes clear that she is finds prayer addressed to God disconcerting. However, prayer addressed to Mary or Jesus is perfectly fine for her. The chaplain recognises how the tensions within the family are connected to tensions between different (a)religious faiths and practices and how the family has nevertheless found various "interreligious compromises". While the Christian–Muslim constellation (father, daughter, son-in-law) speaks of God, the family communicates in Christian–Buddhist conversations by orienting itself towards Jesus and Mary. Knowledge of these special family constellations enables chaplaincy support to be tailored accordingly.[338]

This case study illuminates several aspects of our topic. It shows what the hybridization and increasingly fluidity of spiritual affiliations and identities means for chaplaincy work. Contrary to the prevailing tendency to assume unambiguous affiliations and identities, chaplains must recognise that multiple affiliations and combinations of practices and beliefs from different traditions are now the norm rather than the exception. Furthermore, while religious affiliations, convictions and norms are often difficult to distinguish from cultural ones, they should not be conflated. Importantly, spiritual diversification also takes place within the major religious traditions,[339] and has led

338 Mummenhoff, Interreligiöse Seelsorge im Arbeitsfeld Krankenhaus, 253.

339 This is shown, for example, in Candy G. Brown's study of healing practices in US evangelical circles: Brown, The Healing Gods.

to growing intra-religious differences that chaplains need to take into account. The differences between people who nominally belong to the same religion are sometimes greater than those between people of different religions.

The case study is a reminder that a systemic perspective is particularly important in inter- and transreligious constellations. Healthcare chaplaincy is concerned not only with individuals, but also with their loved ones and with family systems in which the hybridisation of ways of life is amplified. The case study illustrates the importance of considering the different affiliations within such a family system.

Finally, the case study also shows that inter- or transreligious chaplaincy isn't just appropriate when denominational support is unavailable due to organisational constraints. These forms of chaplaincy are not merely an emergency stopgap; they can often be the most fitting form of care. Helmut Weiß pointed out that it can sometimes be helpful "if pastoral care comes from 'outside', i. e. from another faith tradition, in order to make religious fixations more fluid".[340] Melinda Michelson-Carr, a Jewish Rabbi, takes a similar view: "The assumption that people from one's own group are always best able to serve one is not correct. While a shared faith can be the basis for good relationships, there are always other factors at play. […] Some people may even feel more vulnerable if they are supported by someone from the same faith community. If you want to discuss certain issues, a conversation with a stranger might be more comfortable and freer."[341]

As specialists in the field of spiritual care, healthcare chaplains have to prove themselves in religiously complex constellations. Professional inter- and transreligious chaplaincy requires the ability to translate between different religious and spiritual worlds, and this process may already begin while clarifying which chaplaincy services are required. Eberhard Hauschild describes one possible goal of an interreligious chaplaincy conversation: "If both parties are able to participate in the conversation in the light of their religion and in such a way that an image emerges in which each can discern the like-

340 Weiß, Grundlagen interreligiöser Seelsorge, 95.
341 Michelson-Carr, Begleitung auf spirituellen Reisen, 374 f.

ness of their own religion, if both are able to recognise their 'religion-specific credo' in this way, then the interreligious chaplaincy has achieved its interreligious communicative goal."[342] Chaplaincy professionalism also requires that one's actions are informed by an awareness of the limits of one's own understanding and empathy.

With growing religious-spiritual diversity, the demands on interprofessional spiritual care are increasing, which makes the need for a specialised profession all the more urgent. Healthcare chaplaincy can prove its worth as a specialised profession not through pseudo-neutrality in religious-spiritual matters, but through the exercise of professional expertise and the reflective handling of its inescapable positionality. The legitimacy of inter- and transreligious chaplaincy comes from its professional competence and its contribution to the concrete and overarching goals of good healthcare provision. Only to the extent that it demonstrates that it is therapeutically beneficial will healthcare chaplaincy be recognised and supported as a profession in its own right within healthcare. Bearing this in mind, the last chapter will outline what it could mean for healthcare chaplaincy to see itself additionally as a *spiritually* qualified profession.

342 Hauschild, Sprache, 161.

7 Healthcare Chaplaincy as a Spiritual Profession

From its inception healthcare chaplaincy has grappled with the task of learning from psychotherapeutic counselling approaches without becoming merely a variant of them. Opinion has always been divided about how best to strike the balance between spirituality and psychology. Many of the questions that arose in earlier phases of CPE have reappeared with the developments analysed in this book. They draw attention to a fundamental problem which, although not new, now presents itself more starkly: the alignment of healthcare chaplaincy to the therapeutically oriented health professions. Doesn't this process lead to the loss of what is distinctive about healthcare chaplaincy: the focus on the spiritual dimension? Won't the emphasis on the therapeutic character of healthcare chaplaincy, the plea for a "therapeutic chaplaincy", ultimately lead to a distortion of its spiritual character? Or, to put it the other way around: How can we prevent precisely this from happening?

The position of healthcare chaplains working in public institutions is similar (though not identical!) to that of academic theologians. The two professions face a similar challenge: How can the demands of a secular institution be reconciled with an undertaking rooted in a particular faith tradition? Both professions, moreover, rely on reference disciplines and are in danger of merging into them. Just as chaplaincy depends on psychology, theology depends on history, philology, and philosophy.

– This book outlines a way of dealing with this tension that corresponds to Miroslav Volf and Matthew Croasmun's theological manifesto *For the Life of the World*. They understand the practice of theology not merely as an academic discipline, but as part of Christian living.[343] In a similar way, I suggest, healthcare chaplaincy

343 Volf, Croasmun, For the Life of the World, 115–147.

is not just a profession, but a spiritual practice. Several aspects of healthcare chaplaincy contribute to its spiritual character, which should not be reduced to just one:

- a spiritual attitude;
- a vital relationship with a faith community;
- the symbolism of the role of chaplain;
- the competence to perform spiritual rituals in a clinical context.

A Spiritual Attitude as a Hallmark of the Profession

The *Association of Spiritual Caregivers in the Netherlands* emphasises in its guidelines the significance of the attitude of the individual and the integration of personal spiritual resources:

> "[T]he spiritual care giver's personal attitude is an important aspect of the realization of authorization. This attitude arises from the use of religious and worldview sources. The spiritual care giver is able to use those sources in personal life as well as in professional practice, recognizing them and making them available in the guidance of patients and clients. The personal attitude also requires appraisal."[344]

Let us elaborate what this means for the Christian call to healing. Christian chaplains seek to convey something that does not come from themselves. Rather, they receive and bear witness to God's healing presence as a reality through which they become what they are. The radical awareness of having been given everything they have is itself a gift, and not something that chaplains can acquire and possess once and for all. Continually rekindled and nurtured, this awareness can profoundly shape one's life and guide one's actions. Christian chaplaincy, therefore, in inspired by a personal practice of prayer and meditation, through which the 'agents' of chaplaincy may themselves become recipients again and again. Understood in

344 Ten Napel-Roos et al., Non-Denominational Spiritual Care Givers, 63.

this way, the anchoring of chaplaincy in prayer is a distinguishing attribute of the profession.[345]

Although it is undisputed that chaplaincy requires a spiritual attitude, this gives rise to serious questions. Is such a precondition consistent with the separation of the professional and private spheres that is constitutive of modernity?[346] How can one justify making a highly personal attitude a prerequisite for a public role? One might respond either by differentiating the concept of a 'profession', or by pointing out that professional chaplains are distinguished by their cultivated ability to reflect on their personal spiritual backgrounds.

Let us take a closer look at these two responses. The first starts with the observation that the term *profession* originally had overtly religious connotations and combined the public and the personal. The precondition of working as physician, judge or priest was a 'profession' in the literal sense: a public and solemn declaration to act in the best interest of the people and to obey an occupational code. Even in secular societies, traces of this understanding have been preserved, as the inauguration ceremonies of new heads of state demonstrate. Taking an oath of office on Scripture or the Constitution is a confessional act of profound symbolic power. Such a declaration is always public and personal at the same time. There will soon be consequences, if it turns out that the oath-taker was only paying lip service.

In this spirit, the Scottish hospital chaplain Duncan MacLaren calls for chaplaincy to be understood as professional in a double sense: "Professional chaplains are those who bring their whole selves to their work, including the 'profession' of their beliefs and practices. The chaplain who is called to the bedside of a dying person in the small hours of the morning will, at best, turn up 'whole.' […] At best, the roots they 'profess' will allow them to draw carefully from the soil of their own tradition, while always remaining attentive to the needs of the patient."[347]

Self-critical reflexivity is needed to ensure that this recourse to personal spiritual resources is in the service of those in need. Profes-

345 So argues Meyer-Blank, Das Gebet, 57.

346 In this, healthcare chaplaincy is similar to parish ministry and other church professions, cf. Wiedekind, Wertewandel im Pfarramt.

347 MacLaren, All Things to all People, 38.

sional chaplains, such as the CPE strives to foster, should reflect upon the personal foundation of their work in a structured way and take responsibility for it. Unlike other healthcare professionals, chaplains have a duty to provide information about their spiritual backgrounds where necessary.

This applies to all professional chaplains working in public institutions, to be sure. But different contexts require different focuses. For the clinical context, this means bringing to bear one's own spiritual outlook on therapeutic questions. For this reason, chaplains seeking certification by the US *Association of Professional Chaplains* must also submit a spiritual autobiography and are asked "to relate those experiences where one's history directly affects one's clinical chaplaincy".[348] More than their colleagues working in other fields (prison, education etc.), healthcare chaplains are required to develop a spirituality of healing and to nurture a healing spirituality. The abundance of New Testament healing stories and the growing number of healthcare chaplaincy case reports[349] provide a rich matrix for this.

Anchoring in a Faith Community

While a spiritual attitude is a deeply personal requirement for healthcare chaplaincy, the requirement that chaplains be anchored in a faith community is more institutional. However, the personal aspect of this anchoring should not be neglected. As Daniel Grossoehme underlines when reflecting on his chaplaincy experiences in a multi-faith environment: "To live out on those edges of experience so different from my own, I need a spiritual home to go back to."[350]

There are many reasons why a chaplain should be endorsed by a faith community. It ties healthcare chaplaincy back to local congregations and promotes interaction between the clinical and non-clinical

348 Grossoehme, The Role of Science in Enhancing Spiritual Care Practice, 93.
349 Cf. Bobbert, Zwischen Parteilichkeit und Gerechtigkeit, 2015; Fitchett/Nolan, Case Studies in Spiritual Care; Kruizinga et al., Learning from Case Studies in Chaplaincy.
350 Grossoehme, Beliefs Nurture Chaplaincy, 81.

spheres. Moreover, it positions healthcare chaplaincy as part of the faith community's involvement in the healthcare system and enables chaplains to speak and act on behalf of a concrete faith tradition. In this way the community is not merely officially represented, but spiritually present.

But is such an endorsement appropriate when the chaplaincy is financed by the state or the healthcare institutions themselves? In her analysis of US developments Winnifred F. Sullivan formulates the problem succinctly and pointedly: "Such an endorsement […] contradicts the generalizing and equalizing impulse of credentialing professional chaplains broadly to minister to all humans naturally in need of spiritual care without regard to the particulars of any particular religious tradition."[351] There are many variations of this argument and so it requires careful consideration: If healthcare chaplains are to support patients and relatives with different ideological and (non-)religious backgrounds, is it still legitimate (in the strict sense of the word) to make a commission from a particular faith community a significant condition of employment?

Sullivan points to the egalitarian and universalist ethos that informs the US Constitution as well as the Universal Declaration of Human Rights. This universalism, it is suggested, calls for a non-denominational chaplaincy, one that abstracts from the particularities of specific religious traditions. But Sullivan's conclusion is anything but compelling. It is doubtful that there is any such thing as chaplaincy "without regard to the particularities of a specific religious tradition". According to MacLaren, religious and spiritual traditions fulfil a formative function for healthcare chaplains that can be compared to that of the schools of psychotherapy. Psychotherapists, like chaplains, practise in a particular modality:

351 Sullivan, A Ministry of Presence, 128 f. Sullivan's argumentation is guided by court cases dealing with the issue of (non-)discrimination in the employment of chaplains. This problem was also one of the reasons why, since 2013, the Netherlands has recognised healthcare chaplains without ties to a faith community. See Vlasblom, Developments in Healthcare Chaplaincy in the Netherlands and Scotland.

> "Competence in working within one's core modality is a prerequisite for practice [...] having no "spiritual modality" is not an option [...] a chaplain is precisely someone who has been formed within a particular wisdom tradition (Jewish, Buddhist, Sikh, Humanist, and so forth), and has developed the critical skills to be able to draw upon the resources of that tradition, and to critique its weaknesses. [...] it is this rootedness in the spirituality of one or more concrete, historical, wisdom traditions that makes chaplains distinctive and constitutes their "unique selling point."[352]

The Symbolism of the Role of Chaplain

The third factor that imbues chaplaincy with a spiritual character has already been introduced in connection with "initial transference",[353] the process in which patients and relatives spontaneously attribute specific roles to chaplains. These unconscious attributions are the result of culturally formed and socially mediated imaginaries, ideas and expectations. Due to complex historical developments, the role of healthcare chaplains in (post-)secular institutions is not limited to representing a specific religious tradition and community; rather, they embody our connection to an ultimate horizon of meaning, to a transcendent reality. As chaplains, they symbolise personal gateways to the "spiritual dimension", points of contact for all kinds of religious and spiritual questions, longings and needs. They evoke the dimension of the holy: "The difference between chaplaincy and other professions (e.g. psychotherapy and psycho-oncology) lies primarily in the horizon of meaning within which each profession listens, resonates and dignifies. In virtue of its role, chaplaincy always – but not always explicitly – dignifies within the horizon of a transcendent holiness: before God and from God."[354] Chaplaincy communication is determined by this horizon of meaning even when it is not explicitly men-

352 MacLaren, All Things to all People, 36.
353 Gestrich, Am Krankenbett, 19.
354 Weiher, Seelsorge – das machen doch alle, 245.

tioned. This leads to the fourth aspect that qualifies healthcare chaplaincy as a spiritual profession.

Competence in Reflective Spiritual Communication and Ritualisation in Clinical Contexts

In chapter five, the therapeutic quality of healthcare chaplaincy action and being was established not only in terms of its contribution to psychosocial support, but also in virtue of its addressing and representing the spiritual dimension, or in Christian terms: God's presence. Through their spiritual attitude, their anchoring in a faith tradition and the symbolism of their professional role, chaplains fulfil this task often without making the spiritual dimension explicit. Nevertheless, it is critical to the professional profile of chaplains that they be able to articulate and ritually enact this dimension at the appropriate time and in the most fitting manner. As various as the expectations people have of healthcare chaplains may be, they are likely to converge on the basic assumption that healthcare chaplains are qualified and authorised to engage in spiritual practices, to conduct a prayer or ritual or to offer counselling on religious questions, etc. Professionalism in the performance of these practices consists of several mutually interdependent competences. These are:

- *The competence to perceive and discern:* the ability to grasp and articulate the spiritual dimension of the predicament of individuals or whole families in a differentiated and multi-layered way.
- *Communicative and hermeneutic competences:* the ability to address spiritual burdens and resources in a differentiated way and to provide space for narrative.
- *Ritual competencies:* familiarity with particular forms of prayer, rituals, spiritual communication etc.[355] Established rituals and personally acquired forms of prayer enable spontaneous action in critical situations.

355 According to Meyer-Blank, Das Gebet, 55, "learning to pray publicly" is a characteristic of pastoral education.

– *Field competence:* This consists in a familiarity with clinical contexts and the specific needs and limitations of the sick, the dying and the grieving.

Competences are not all. If professionalism involves knowing and being able to describe the limits of one's professional competence and responsibilities, this is especially true in this context. The chaplain's positionality, belonging and training makes some spiritual actions possible, while others are, for this reason, unavailable. A Christian chaplain, even one well versed in Islamic legal issues, cannot assume the role of a legal expert for a Muslim family divided on a question of medical ethics. Without being enabled and endorsed by faith communities, healthcare chaplains have fewer options, not more.

Review and Outlook

Let us return to the agate windows with which Sigmar Polke transformed the light within Zurich's Grossmünster in 2009. The most resplendent of all is the half-circle lunette window above the exit portal.[356] Here the arrangement of the agate slices is partly symmetric, left and right of the centre line. If you linger in contemplation of this window, you may suddenly find two large, black eyes staring back at you, formed out of two large, dark stones. In the otherwise bright and colourful mosaic they are disconcerting and seem out of place. Are they the eyes of a demon of the threshold, guarding the entrance and exit? However, you interpret these eyes, they bring to mind the dangers and anxieties that often accompany liminal situations – including the one to which this book is dedicated: the transition of healthcare chaplaincy into a specialised healthcare profession.

Let us conclude by calling to mind the lines of thought that have been developed in this book. To begin with, we had an analysis of the current situation and the observation that there are many mutually reinforcing processes of transformation involved: the rediscovery and reintegration of the spiritual dimension in a highly specialised and globalised healthcare, the spiritual pluralisation of society, and the emergence of new, post-secular framework conditions for healthcare chaplaincy work.

While the first part delineated global upheavals, the second described the Christian call to healing. I have argued that this call remains not only essential to the Church's mission today but provides a sound theological basis for Christian spiritual care. It was also shown that this task is not limited to diaconal care of the sick, the vulnerable, the dying and the grieving, but encompasses distinct

356 Cf. https://www.grossmuenster.ch/de/das-grossmunster/kunst-am-bau/polke-fenster/ (21.11.2023).

forms of therapeutic work aimed at the relief of all kinds of suffering: somatic, mental, social and spiritual. In current circumstances, this mission includes sharing responsibility for the fair provision of the best possible healthcare. Christian involvement in healthcare can mould and transform it "from within".

With regard to the conception of healthcare goals, the Christian difference is manifest in three ways: in the motivational embedding of the commitment to good and humane healthcare, in the elaboration and specification of therapeutic and health policy goals, as well as in specific convictions regarding therapeutic factors. Contrary to the tendency to narrow 'healing' to the curative dimension, conceived biomedically, it must be understood in a differentiated way from both medical and theological perspectives. The goals of contemporary healthcare also include palliative, preventive, rehabilitative and ethical goals, as the *Hastings Center Report* stresses. To quote the central passage once again: "The healing function of medicine encompasses both curing and caring, and healing may in a broader sense be possible even in those cases where medicine cannot cure. It can heal by helping a person cope effectively with permanent maladies."[357]

In a complex healthcare sector, the Christian call to healing can be fulfilled in many different ways: through professional engagement, as well as through political involvement or voluntary support. It cannot be limited to any one of these forms but depends on the interplay of different kinds of expertise and skill. Christian healthcare chaplaincy is situated *within* this general mission and is a specification of it. This puts it into a healthy perspective. In its efforts to incorporate the spiritual dimension into a secular healthcare sector, it is not alone.

In order to specify more closely the therapeutic quality of healthcare chaplaincy in the context of the Christian call to healing in today's healthcare sector, I have drawn on Dietrich Stollberg's central insight that chaplaincy work influences therapeutic processes – positively or negatively – whether this is intended or not. The ascription to healthcare chaplaincy of a therapeutic nature is thus doubly

357 Callahan, The Goals of medicine, 12.

justified: in virtue of its mission and through its effects. If only for ethical reasons, chaplains are therefore obliged to be alert to the consequences of their actions, to examine them and to take responsibility for them. Professionalism is expected of healthcare chaplaincy, unlike voluntary work.

However clearly this expectation is articulated today, there is no simple answer as to what professional form therapeutic chaplaincy should take. In an exploration of outcome-oriented chaplaincy, it was suggested that there are two factors to healthcare chaplaincy's contribution to therapy, which can be thought of under the rough headings of "meaning" and "presence". By creating space for ultimate meaning as well as through healing presence, chaplains can make a substantial contribution to the achievement of palliative, rehabilitative, preventative and curative goals.

While the second part dealt with the specification of the place of healthcare chaplaincy within the Christian call to healing, the third part examined the processes transforming healthcare that were outlined at the beginning, processes which are leading to the realignment of healthcare chaplaincy in several respects. The more spiritual care is perceived as an interprofessional task, the more important it is for chaplains to distinguish themselves as a specialised profession focused on the spiritual dimension.

To establish itself as an independent profession in healthcare, further clarification of its professional role and ethos is necessary. It was shown how increasing specialisation and religious diversity has given rise to the task of integrating different chaplaincy sub-roles and of determining anew the possibilities and limits of the profession. The challenges outlined at the end of the third part, which arise from various inter- and transreligious constellations, led us back to the question how to ensure that what is distinctive about healthcare chaplaincy is not merely preserved as it is professionalised, but further elucidated and clarified: the focus on the spiritual dimension.

In a post-secular society with increasing diversity in the domain of religion and spirituality, there is a need for experts who know their way around this confusing field and are able to mediate in conflict situations. Given this situation, healthcare chaplaincy is assuming a

new significance as a distinctively spiritually profession. Chaplaincy will find its *proprium* within the scope of the Christian call to healing not through sharp contrast with the therapeutic work of (other) health professions, but rather by sharpening its spiritual profile as a "companion profession" within a common field of work.

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