Theological Perspectives and Integration of Religion and Spirituality into Health Care[1]

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1. Religiosity and Health in Modern Medicine

Modern medicine makes use of the natural sciences and their methods, which forgo the "God hypothesis", explaining sickness and health „etsi Deus non daretur". Up to modernity, the cultural history of sickness and health is, to a great extent, the history of religion. Only the advent of modern medicine, based on natural science, leads to a separation of medicine and religion, and thus also of healing and salvation – unless, that is, the elevation of health to the highest good is to be understood as a new form of religion, and as a search for transcendence in the immanence of a society that suffers from a loss of transcendence. Yet there are also conspicuous religious connotations among the different varieties of alternative or holistic medicine, which are directed against so called Western academic medicine ("Schulmedizin").

Meanwhile, however, in medical science there is renewed interest in the religious dimension of sickness and health. In recent years, a number of investigations have been published in medical journals, which suggest a positive influence of religion and spirituality on the healing process and on the individual's coping with sickness.[2] Over the last years, the number of publications on spirituality, religion and faith in medical and nursing science journals has risen dramatically.[3]

In 1995, the World Health Organization incorporated the complex, "spirituality/religion/personal beliefs", as a separate section into their survey for the ascertainment of health-related quality of life, since many patients considered it to be important (WHO survey WHOQOL-100). In some circumstances, patients and their families need not only psychological but also pastoral assistance. Cooperation with hospital

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[2] Cf. Kenneth I. Pargament, The Psychology of Religion and Coping. Theory, Research, Practice, New York 1997.

[3] Cf. Michael Utsch/Raphael M. Bonelli/Samuel Pfeifer, Psychotherapie und Spiritualität. Mit existentiellen Konflikten und Transzendenzfragen professionell umgehen, Berlin/Heidelberg 2014.

chaplaincy – not only with representatives of Christian churches, but also with those of other religious communities – belongs to a good therapeutic and nursing process.

According to the WHO definition, spiritual support constitutively belongs to the concept of Palliative Care, which is defined by the WHO as follows: "Palliative care is an approach that improves the quality of life of patients, and their families, facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial *and spiritual* [italics U.K.]". Palliative Care "integrates the psychological and spiritual aspects of patient care" und "offers a support system to help the family cope during the patients illness and in their own bereavement".[4]

Today, the positive, life-serving aspects of religion are readily used to designate the concept of "spirituality". Many people view "spirituality" as a non-Christian form of religiosity, not connected to any church or dogmatic theology. Today, the term is applied as though it were a given for non-Christian, and especially Far Eastern religions. That the word actually originated in Christianity is often completely overlooked. The problematic transfer of originally Christian concepts to non-Christian religions gives rise to the impression that the religions essentially agree, the essence of religion being determined in a rather diffuse sense as "mystical". Many seem completely unaware that, in this way, a distortion and absorption of other religions occurs. On this point, today's Religious Studies is far more reserved than some proponents of a syncretistic theology of religions.

In the following, I wish to make the case for a careful and critical handling of the the concept of spirituality in general, and in medicine in particular. First, (2.) I provide some references to the history of the concept and its Christian content. Following this, (3.) I discuss the term and concepts of Spiritual Care.[5] In medical as well as theological and pastoral perspective, I consider it to be crucial in this discussion not only to stress the positive sides of religion and spirituality, but also to bring up their ambivalences and possible dangers. That will be the topic of the penultimate section (4.) of my paper. Finally, (5.) I wish to put forward for discussion an expanded concept of spirituality, which I develop in six theses.

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[4] WHO Definition of Palliative Care, http://www.who.int/cancer/palliative/definition/en/. Cf. also the guidliines for Palliative Care in Switzerland: Bundesamt für Gesundheit (BAG)/Schweizerische Konferenz der kantonalen Gesundheitsdirektorinnen und -direktoren, Nationale Leitlinien Palliative Care (GDK), Bern 2010 (http://www.bag.admin.ch/themen/gesundheitspolitik/13764/13768/13784/index.html?lang=de).

[5] Cf. Eckhard Frick/Traugott Roser (eds.), Spiritualität und Medizin. Gemeinsame Sorge für den kranken Menschen (Münchner Reihe Palliative Care, vol. 4), Stuttgart ^{2}2011; Isabelle Noth/Claudia Kohli Reichenberg (eds.), Palliative und Spiritual Care. Aktuelle Perspektiven in Medizin und Theologie, Zürich 2014.

2. The Concept of Spirituality

In its contemporary meaning, "spirituality" is a term both young and vague.[6] It became prevalent as a synonym for piety in the French language at the end of the 19th century. Within Catholicism, spirituality indicates various Catholic ways of life and special practices of religious devotion such as, for example, religious exercises. The term was first adopted in German-speaking Protestantism during the 70s of the last century. In the ecumenical context, "spirituality" is at times not only equated with piety, but also with religiosity in the most general sense.

At present, "*Spiritualität*" is also a fashionable word in German usage. As such, it is by no means any longer limited to forms of Christian religious devotion, but shows up in every possible form of new religiosity. Originally understood under "spiritus" is the Holy Spirit, in accordance with the biblical tradition and the Christian doctrines of faith. Nevertheless, over the centuries, the concept of Spirit has also largely lost its Christian profile. In postmodern religiosity, "Spirit" stands for a person's unspecific intellectuality or inwardness, for cosmic energies and healing powers, for the longing for wholeness, mysticism and "spiritual" expansion of consciousness.

Thus, Christian contemplation, Zen-Buddhist meditation and Yoga, the mysticism of Islamic Sufism and Jewish Cabbalism, but also New-Age thought, Anthroposophy and Theosophy, Western notions of reincarnation, magic, spiritism and occultism, pendulum dowsing, astrology and fortune-telling techniques like cartomancy or palm-reading, practices of alternative medicine like faith-healing by the laying on of hands or healing stones and Bach flower therapy can all operate under the designation "spirituality". And we quite often encounter various syncretistic blends and Western adaptations of elements of Eastern religions on the esoteric market of possibilities.

When spirituality and its integration in the Healthcare System is considered as a possible component of medical action, then it becomes necessary define the concept of spirituality more precisely. For, the lack of disambiguation necessarily also leads to methodological defects in clinical studies about the possible influence of spirituality or religiosity on

[6] On the following cf. Ulrich H.J. Körtner, Wiederkehr der Religion? Das Christentum zwischen neuer Spiritualität und Gottvergessenheit, Gütersloh 2006, 95ff; id., Die Gemeinschaft des Heiligen Geistes. Zur Lehre vom Heiligen Geist und der Kirche, Neukirchen-Vluyn 1999, 11ff.

therapeutic processes. Following David B. Larson's definition, the Viennese Interreligious Doctors-Platform distinguishes between religion, religiosity, and spirituality. *Religion* is understood to be "an organized system of faith, practice and symbols, which should aid the approach to a higher power", *religiosity* is understood to be "a personal disposition […], which constitutes a collective concept for religious consciousness and behavior", and *spirituality* is understood to be "a personal, meaningful, basic mindset, which represents a transcending self-reflection, which religious thought can but does not have to comprise"[7].

This distinction is undoubtedly helpful, as recent sociology of religion studies confirm.[8] It is also to be asserted from a theological perspective that religion gives a particular answer to the question of meaning, and yet, that not every answer to the question of meaning is to be labeled as religion.[9] Of course, with respect to a conceivably broad conception of spirituality, it has to be kept in mind that the concept in question is innately religious.

In the Christian context, which is its native soil, spirituality designates the Christian life in general. In the biblical sense, this life is to be understood as *spiritual life*. Spiritual life is a life from the Holy Spirit, which means living out of the Spirit of God, who has ultimately revealed himself in Jesus of Nazareth. For this reason, in the Bible, the Spirit of God is also called the Spirit of Christ.[10] Therefore, spiritual life, as the totality of Christian conduct of life, is a life of faith, love and hope in the unity of love for God and neighbor. The twofold law of love is the epitome of Christian spirituality and the Christian service of God, which consists not only in the Sunday assembly of the Christian community around the word and sacrament, but also (in the sense of Rom 12:1) in the everyday conduct of life according to the commandment of love.

Linked to the modern desire for spirituality, which is unaware of this Christian context, is a rather vague hope of salvation, namely, the desire for wholeness.

3. Spiritual Care

The World Health Organization (WHO) defines the Healthcare System as the entirety of all institutions that offer goods and render services for the preservation or restoration of human

[7] Christoph Gisinger et al., Seelsorge und Spiritualität bei Krankheit und Pflege, Österreichische Ärztezeitung 15/16, 15.8.2007, 28–29, here 28.

[8] Cf. Georg Datler/Johann Kerschbaum/Wolfgang Schulz, Religion und Kirche in Österreich. Bekenntnis ohne Folgen?, SWS-Rundschau 4 (2005) H. 4, 1–23.

[9] Cf. Körtner. Wiederkehr (fn. 6), 27ff.

[10] E.g. Rom 8:9; Phil 1:19; 1 Pet 1:11.

health, as well as those institutions which make contributions to the effect that persons can, with their sickness or disability, lead a life with the best possible quality of living. The possible integration of Spiritual Care and the Health Care System has to be considered on three levels: the personal level, or respectively, the level of interactional relationships, e.g. between doctor and patient; the structural or institutional level, on which e.g. the hospital or the whole Healthcare System as systems or organizations come into view; and finally the cultural level, on which mindsets and values (i.e. also basic world-view or religious orientations) are located.[11] These basic mindsets and moral conceptions influence the personal as well as the structural levels.

On the one hand, contemporary concepts of Spiritual Care take individuals and their religious or spiritual needs into account, and on the other hand they consider the structures in which Spiritual Care is practiced. Just as much as the individual patient should occupy the center of medical proceedings and helping actions, so also the concrete locations of helping and healing action, the institutional and organizational parameters, must be born in mind. This applies not only to the structures and working conditions, e.g. in a hospital or special-care home, but for the Health Care System in general.

This is taken into account by the different concepts of "Spiritual Care" which have been developed in the USA and Great Britain. In the meantime, this discussion has also reached German-speaking areas, where it is also concerned with redefining the task and role of chaplaincy in hospitals. As Traugott Roser writes, the actual innovation in the establishing of chaplaincy consists "in that it is no longer argued for solely from the patient's right to pastoral care as a concretion of religious freedom; rather, an institutional interest, described according to institutional criteria (quality management), is cited, which for its part is consistently patient-oriented in the sense that the patients' subjective satisfaction and quality of life has central significance for the understanding of quality"[12]. Thus, "Spiritual Care" is to be understood as a systemic concept, by the help of which the chaplaincy of the different religious communities is to be organizationally integrated into the system of the hospital.

Yet, the concept of Spiritual Care requires several conceptual clarifications and raises a number of religio-theoretical and theological questions. In the USA, there is discussion between conservative and liberal theologians about the pros and cons of "Spiritual Care" as

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[11] Cf. Eberhard Amelung, in: id. (ed.), Ethisches Denken in der Medizin. Ein Lehrbuch, Berlin et al. 1992, 19–53; Dietrich Ritschl: Zur Theorie und Ethik der Medizin. Philosophische und theologische Anmerkungen, Neukirchen-Vluyn 2004, 134.

[12] Traugott Roser, Spiritual Care. Ethische, organisationale und spirituelle Aspekte der Krankenhausseelsorge. Ein praktisch-theologischer Zugang (Münchner Reihe Palliative Care, vol. 3), Stuttgart 2007, 264.

distinct from "Pastoral Care", that is, confessionally informed pastoral counseling.[13] It is here that Palliative Care plays a pioneering roll. In German-speaking countries there are also indications of the loosening of the confessional ties of chaplaincy in favor of a "Spiritual Care", that is not connected to any concrete religious tradition.[14] It remains to be seen which long term, structural consequences this will have for hospital chaplaincy.

Behind the clarity or vagueness of the concepts of "spirituality", religiosity and religion, are by no means only scientific interests of theory construction. Rather, there are also the pragmatic questions of competent occupational groups responsible for Spiritual Care, of organizational incorporation and recruitment of chaplains (affiliation with a specific religious community, commissioning by a religious community), of contents, methods and related sciences for education, further training and education (Theology, Religious Studies, Philosophy, Psychology and Psychotherapy).[15]

Traugott Roser considers the vagueness of the concept of "spirituality" to be its strength in the context of hospital chaplaincy and Spiritual Care. According to her, this strength consists in its compatibility with the different forms of the search for and giving of meaning in a religiously and ideologically pluralistic society. In the most general sense, according to Roser, the concept stands for radical individuality in an environment that, in diagnostics, therapy and nursing, is calibrated for generalizations and comparability. Thus, for Roser, the concept of spirituality, in its vagueness, serves in the determination of the indeterminable, the highlighting of differences, without which freedom and individuality are unthinkable and, especially, incapable of being experienced. Theologically, Roser interprets the indeterminability, thematized via the semantics of spirituality, as inaccessibility, which distinguishes the human being as the creature and likeness of God, that is, as a being open-to-the-world, designed for relationship (including transcendent relationships), but also fragmentary, vulnerable and finite.[16] Yet, inaccessibility is also another word for contingency, which, for example, is experienced in the success or failure of therapeutic processes. Roser defines Spiritual Care as "Care for the individual taking-part-in and having-part-in a meaningful life, comprehensively understood"[17].

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13 Cf. the contributions in Christian Bioethics 9, Nr. 1, April 2003.

14 Cf. Ulrich H.J. Körtner, Ethik im Krankenhaus. Diakonie – Seelsorge – Medizin, Göttingen 2007, 203–224, here 219ff.

15 See also Michael Utsch, Wer sorgt für die Seele eines kranken Menschen? Das Konzept „Spiritual Care" als Herausforderung für die christliche Seelsorge, MEZW 75 (2012) H. 9, 343–347.

16 Cf. Roser, Spiritual Care (fn. 12), 252.

17 Roser, Spiritual Care (fn. 12), 9 and 278.

Nevertheless, despite all due sympathies for compatibility among pluralistic life-worlds and discourses, for reasons scientific as well as pragmatic, I consider the quest for conceptual differentiations to be necessary. Thus, in my assessment, it is necessary – despite all factual overlappings – to differentiate between spirituality, religiosity and religion, since otherwise the objects of possible knowledge remain unclear and the determination of different ranges of duties and competences in the area of healthcare becomes impossible. For example those who, like the Protestant theologian Manfred Josuttis (following Rupert Sheldrake's theory of morphogenetic fields and the Far Eastern Chakra teaching), conceive of the Spirit of God as a cosmic force field, and consider the chaplain to be a guide into the holy,[18] bracket out not only the social and political dimension of the understanding of the human body, but also (as Christoph Schneider-Happrecht rightly criticizes) "in the attitude of apparently all-powerful spiritual healers" bypass "the doctors' and therapists' efforts at healing"[19]. This form of spirituality is itself reductionist, since it is based on an ontological monism which, ultimately, is merely a variant of the criticized natural-scientific materialism or physicalism. "The monistic perspective of the divine, vital force which floods the cosmos, with which [this form of Spiritual Care] aligns itself", exempts it "it seems, from the question of the perspectives of others."[20]

A controversial question is also, to what extent contemporary forms of a Christianly grounded and oriented hospital chaplaincy, or alternatively, an open offer of Spiritual Care, should or should not become an integral component of hospitals or care facilities. The demand has been made to develop chaplaincy or Spiritual Care into the fourth pillar, alongside medicine, nursing and economy.[21]

In Germany and Austria, chaplains are recruited and paid by the regional Church, or they are employed by a diaconal sponsor. However, among the various regional Churches, clinical, pastoral counseling is very differently equipped with personnel.

In any case, the growing scarcity of financial resources compels churches, hospitals and retirement homes to examine their form of collaboration in the area of chaplaincy, as well as its existing concepts and financial models. If chaplaincy is thought of as a service, then it

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[18] Cf. Manfred Josuttis, Segenskräfte. Potentiale einer energetischen Seelsorge, Gütersloh 2000, 39.52f.232.

[19] Christoph Schneider-Harpprecht, Leib-Sorge? Die Wiederentdeckung des Leibes in der Seelsorge, in: id./Sabine Allwinn, Psychosoziale Dienste und Seelsorge im Krankenhaus. Eine neue Perspektive der Alltagsethik, Göttingen 2005, 202–222, here 219.

[20] Ibid.

[21] Sabine Allwinn/Christoph Schneider-Harpprecht/Kristina Skarke, Psychosoziale Dienste und Seelsorge als vierte Säule im Krankenhaus, in: Schneider-Harpprecht/Allwinn (eds.), Psychosoziale Dienste (fn. 18), 223–245.

becomes concievable that this service might no longer be financed by the regional Churches, but charge the customer instead. This would probably not be the individual patient, but the hospital or retirement home, provided that hospital chaplaincy does not restrict itself to the accompaniment of patients and their immediate family, but takes on a clearly defined function for the entire organization of the institution, e.g. by incorporation into an ethics committee, by pastoral support of the personnel and coworkers and assistance in the drawing up and implementation of the mission statement. In this model, the chaplains continue to be employed by the regional Church and work on its behalf. However, the costs are shifted in part or as a whole over to the sustainer of the hospital or retirement home.

Of course, such a model can only function if the non-church supporters of the hospital can be made to see what systematic or organizational benefits are to be had from the offer of hospital chaplaincy. There are calculations that show, that the pastoral accompaniment of patients has a cost-cutting effect, since it positively influences the compliance and coping of patients, contributing thereby to a shorter length of stay in the hospital. It also raises the satisfaction of patients (who are thought of as customers), and serves the cultivation of the hospital's image, since patients (and their immediate family) have fond memories of the hospital after being released, and thus recommend it to others.

Considerations such as these have led to a different business model in the USA and Great Britain. Here, in the course of privatization, or of the reorganization of government-run clinics in the British New Health Systems as "trusts", hospitals have made the transition to organizing chaplaincy as a separate department and component of the organization. However, in this model, chaplaincy loses its traditional church-based, confessional profile. "Pastoral Care" alters itself in the direction of a religiously pluralistic "Spiritual Care" that is meant to also satisfy the spiritual needs of people who have no close connection to a Church or other religious community and its convictions and rituals. However, the consequences of the economization of healthcare are observable in Switzerland, Germany and Austria. Even in the the branch of welfare and social work of the Churches [*Diakonie*], quality control and quality management are viewed as matters of course.

The Catholic theologian, Georg Meier-Gerlich, developed the concept of a charitable pastoral care on the basis of the theology of organizations, which starts from the premise that theology and social systems enter into a close alliance in welfare and social-work ventures.[22] According to this concept, pastoral care, analogous to medicine and nursing, is also results-

[22] Georg Meier-Gerlich, Caritative Seelsorge im Behandlungsauftrag des kirchlichen Krankenhauses. Ein Modell zur Professionalisierung der Krankenhausseelsorge, Trier 2003.

oriented and uses a methodological instramentarium consisting of the initial pastoral consultation, the pastoral counseling diagnosis by means of a questionnaire, a treatment plan and a systematic evaluation.

The positive side of this concept is that it reasonably delimits the task of chaplaincy and, with a clear profile and assignment, integrates it into the work of a therapeutic team (for example, in oncology or an internistic station). However, the concept's border to psychotherapy is in need of clarification when Meier-Gerlich explains that the task of chaplaincy is to treat the psychological wounds which disturb the balance of the patient's emotional household, value-system and religious convictions. Is it permissible and sensible – also from a theological point of view – to understand chaplaincy as a success-oriented process? If the central event in chaplaincy is to be understood as a spiritual process, in which the Gospel takes hold of the individual – when and how it pleases God –, can this process be directed and evaluated at all?

The Protestant practical theologian Isolde Karle rightly points out that chaplaincy, as a religiously coded dialogue (or respectively religion itself), cultivates "equivocations and ambiguities, which elude a simple instrumentalization of religion for the health of believers, and maintains an awareness of *the unknowable, of the incalculable, of the fundamental doubt*, which accompany the believer"[23]. Christian chaplaincy is, first of all, free of specific goals and, as distinct from psychotherapy or consulting, "*not primarily* to be understood *as working for change*, not even in the service of health"[24]. Isabelle Noth is also convinced "that chaplaincy is something significantly different from medically shaped (Western-secular) Spiritual Care" [25]. And, when she looks at measuring instruments like SPIR – a "half-structured clinical interview for the elicitation of spiritual anamnesis"[26] (developed at the Munich Department for Spiritual Care) – where the first question reads: "Would you consider yourself, in the broadest sense, as a believing (religious/spiritual) person?", then the spontaneous reaction of the chaplain-Noth is: "Hopefully the person also dares, given the asymmetry of doctor and patient, to withhold the information"[27].

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[23] Isolde Karle, Perspektiven der Krankenhausseelsorge. Eine Auseinandersetzung mit dem Konzept des Spiritual Care, WzM 62 (2010) 537–555, here 543.

[24] Karle. Presepktiven (fn. 23), 547.

[25] Isabelle Noth, Seelsorge und Spiritual Care, in: id./Cl. Kohli Reichenbach (eds.): Palliative und Spiritual Care (fn. 5), 103–115, here 115.

[26] Cf. dazu Stefan Tobias Hauf, Das halbstrukturierte, klinische Interview „SPIR" zur Erfassung spiritueller Überzeugungen und Bedürfnisse von Patienten mit Krebserkrankung, 2009 (abrufbar unter http://edoc.ub.uni-muenchen.de/10263/1/Hauf_Stephan.pdf [last accessed on 21.3.2016]).

[27] Noth, Seelsorge (fn. 25), 113.

4. The Ambivalence of Religion and Spirituality

Also questionable is the thesis according to which spirituality, in every case, has positive effects on mental or bodily health. Studies which desire to empirically corroborate this connection find themselves exposed to scientific-theorical and methodological queries. This applies, for example, to diverse studies which have investigated the therapeutic effect of prayer. In any case, these studies cannot answer the question, whether or not God exists. Possible evidence of a therapeutic effect of prayer is no proof of God's existence, but can also be explained as a placebo effect. Apart from that, the available findings on the therapeutic effects of prayer are contradictory. For example, while a study published in a British journal thinks itself able to demonstrate that regular praying of the Rosary or meditative mantras has a positive effect on the heart and circulatory system[28], other studies arrive at the conclusion that prayer – at least among heart patients – has no demonstrable healing effects.[29] Aside from the question of the design and conclusiveness of the mentioned studies, it is basically to be maintained that medical and psychological investigations of the effects of prayer, or of the mental fortification of patients through their faith, reveal nothing about the *truth* of a religion, but rather, at best, something about their possible individual effects. Humor, for example, also has a positive effect on the course of therapy and coping. The work of the CliniClowns and the "Red-Nose Clown Doctors" [30] comes to mind here.

Of course, one could just as well investigate the anxiety-producing or anxiety-intensifying effects of certain religious notions – religious ideas of guilt and sin, of divine punishment, hell and purgatory, all come to mind – and their negative effects on the courses of illnesses. The deluded religious worlds of psychotics are also a sufficiently well-known field of research.[31] The refusal of life-preserving medical measures on religious grounds, e.g. the

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[28] L. Bernardi/P. Sleight et al., Beyond science? Effect of rosary prayer and yoga mantras on autonomic cardiovascular rhythms: comparative study, BMJ 2001; 323: 1446–1449.

[29] M.W. Krucoff et al., Music, imagery, touch, and prayer as adjuncts to interventional cardiac care: The Monitoring and Actualization of Noetic Trainings (MANTRA) II randomised study, The Lancet vol. 366, nr. 9481 (16. Juli 2005), 211–217; H. Benson et al., Study of the Therapeutic Effects of Intercessory Prayer (STEP) in cardiac bypass patients: A multicenter randomized trial of uncertainty and certainty of receiving intercessory prayer, in: American Heart Journal, vol. 151, nr. 4 (April 2006), 934–942.

[30] Information under http://www.cliniclowns.at/ (last accessed on 14.1.2016) and https://www.rotenasen.at/ (last accessed on 14.1.2016).

[31] See the classic case of Daniel Paul Schreber and his his analysis by Sigmund, Psychoanalytische Bemerkungen über einen autobiographisch beschriebenen Fall von Paranoia (Dementia Paranoides), GW III, Frankfurt a.M. [5]1969, 239–320. Cf. further Caspar Kulenkampff, Entbergung, Entgrenzung, Überwältigung als Weisen des Standverlustes. Zur Anthropologie der paranoiden Psychosen, in: Erwin Straus/Jürg Zutt (eds.), Die Wahnwelten (Endogene Psychosen), Frankfurt a.M. 1963, 202–217; Alfred Storch/Caspar

Jehovah's Witness' principal rejection of blood transfusions, also has negative effects on the chances of healing and survival. The interactions between religion, health and sickness are quite complex.[32] Simple answers and explanations are fundamentally to be mistrusted, not only from a scientific but also from a theological point of view, since the ambivalences of every form of religion are not only a topic of the modern critique of religion, but also of theology, in any case within Christianity.

It is not only religious notions of a punishing God or the eternal torments of hell, which can have deleterious health consequences, but also certain forms of esotericism and alternative medicine.[33] There are questionable, even down-right criminal examples of this in the area of psycho-oncology.[34] Inasmuch as the source of the cosmic power of nature is presumed to be with in the individual, the appeal is made to the personal responsibility of the individual for his or her own destiny. For example, sickness is interpreted as self-healing, while the socio-ethical dimension of responsibility for the world takes a backseat.[35]

Of course, the justified critique of the negative phenomena and consequences of religion or spirituality can do nothing to obscure the fact that the human person does not live from bread alone, and is not capable of being reduced to metabolic processes and the satisfaction of material needs. It is likewise incontrovertible that, in individual cases, persons can gain strength from their religious faith – can, not must! –, which helps them master crises of life, such as, for example, a serious illness, or perhaps enables them to accept some incurable suffering or disability without breaking down mentally and emotionally [= seelisch].

Kulenkampff, Zum Verständnis des Weltuntergangs bei den Schizophrenen, in: Der Nervenarzt 21 (1950) 102-108.

[32] Generally, on the phenomena of negative religious coping cf. D. Edmondson/C.L. Park/T.O. Blank/J.R. Fenster/M.A. Mills, Deconstructing spiritual well-being: existential well-being and HRQOL in cancer survivors, Psycho-Oncology 17 (2008) 161–169.

[33] From the perspective of consumer protection cf. also Stiftung Warentest/Verein für Konsumenteninformation, Die Andere Medizin. Nutzen und Risiken sanfter Heilmethoden (in Zusammenarbeit mit K. Federspiel u. V. Herbst), Berlin ^{4}1996.

[34] The convicted doctor, Ryke Geerd Hamer, comes to mind here. Cf. Ryke Geerd Hamer, Krebs. Krankheit der Seele. Kurzschluß im Gehirn, dem Computer unseres Organismus. Die EISERNE REGEL DES KREBSES, Köln ^{4}1989.

[35] Cf. Susanne Heine's critique: Die Erfahrung Gottes in einer von menschlichem Handeln bestimmten Welt, ZThK 93 (1996) 376–392.

5. An Expanded Concept of Spirituality in Medicine and Nursing[36]

A materialistic reductionism, that dismisses the question of meaning and the dimension of transcendence, is just as problematic as some conceptions of holism, which would attribute all illnesses to psychological or spiritual causes. A spirituality that propagates positive thinking as a miraculous weapon against all somatic ailments fails to recognize the difference between well-being and healing and, in my theological understanding, is just as reductionistic as modern materialism. For the sake of life, one-dimensionality has to be epistemologically and practically overcome in favor of multidimensionality. Yet, in my opinion, a concept of integrative medicine which aims at multidimensionality should take the place of a dubious holistic medicine.[37]

In practice this means, that not only somatic medicine and psychotherapy, but also medicine, nursing, philosophy and theology have to enter into conversation with each other to a greater extent than as is now the case, and that this take place not only in the area of a medical ethics essentially reduced to risk assessment, but in the area of fundamental anthropological questions. The right to pastoral or spiritual support belongs to patients' rights established by law. The teamwork of health professions and religious chaplains must take the place of extreme division of labor, if the human person is not to disappear from view. The calculation according to which well-being and healing are to be neatly separated, so that medicine is exclusively concerned with health and healing and theology at most for well-being and salvation, does not work out in its previous, somewhat Kantian form. Health and well-being, healing and salvation, being and meaning all concern the human person, in itself indivisible, who is more than the sum of his or her anatomical, psychological and mental parts.

In what sense is it possible to speak in a theologically responsible way of spirituality in medicine. I would like to name several elements:

1. "Professional attitudes"

The word, spirituality, comes from the Latin "spiritus = spirit". What is meant is the divine Spirit, who wants to and ought also to gain ground in the human person. The pertinent question of spirituality is: In which Spirit do I do my work, practice my profession, and

[36] This section is taken from Körtner: Leib und Leben (fn. 1), 104–107.

[37] Cf. Ulrich H.J. Körtner, Wie lange noch, wie lange? Über das Böse, Leid und Tod, Neukirchen-Vluyn 1998, 53ff.

encounter other people? In other words, spirituality has something to do with "professional attitudes" of doctors and nurses. Empathy, love of neighbor, care and compassion are spiritual gifts which, in my understanding, should inform the basic attitude of physicians and nurses.

2. Accepting Finitude

Spirituality is aware of the gift-character of life and health, of their inaccessibiliy and contingency. With all due respect for professionalism, the success of spiritual processes is nevertheless a grace and an occasion for humility and thankfulness. An old saying goes: "Medicus curat, natura sanat, Deus salvat". Healing does not rest solely in the hands of humans. Spirituality in medicine and health care system means accepting one's own finitude. However, this means also accepting the finitude of the healing arts, so as not to overly exalt them. Spirituality consists in the mutual unburdening of doctors, nurses and patients from exaggerated expectations, and in learning to deal with break-downs and failures. This is an especially virulent issue in the case of incurable or chronic sickness.

3. Medicine and nursing – an Art

It is a pertinent insight of spirituality that medicine and nursing is not only a technique, but but also an art, which, like all art, requires inspiration and kairos, the right timing and the fateful moment. "There is often an unspoken conviction, that doctors or nurses solve problems in a merely technical manner, appropriate to the object at hand [sachgerecht]. If that were in fact the case, then the doctors concerned would be medical technicians who would not deserve to be called doctors, and the nurses would be nursing robots, who would not deserve to be called nurses."[38]

4. The Resource of Trust

Spirituality in medicine and nursing has fundamentally to do with the resource of trust, without which therapeutic and nursing processes cannot be successful. Doctors and nurses require self-confidence and trust in their abilities and the means at their disposal. Patients and their families need to have confidence in the healing and nursing arts of the doctors and nurses. Trust is accepted dependence, as the physician and Protestant theologian Dietrich

[38] Kath. Krankenhausverband Deutschlands e.V. / Deutscher Evangelischer Krankenhausverband e.V., Ethik-Komitee im Krankenhaus. Selbstverlag des Kath. Krankenhausverbands Deutschland e.V., Freiburg i.Br.1997, 9.

Rössler once wrote.[39] Herein lies an indication of the awareness of absolute dependence, which the Protestant theologian Friedrich Schleiermacher described as the essence of religion. Trust is, if you will, always also a matter of faith. Faith, not only in the competence of a doctor, but faith in God as the depth-dimension of our existence, is the ultimate ground of all trust. It pertains to spirituality to lay bare this depth-dimension of human trusting and hoping, and to go in search of sources of trust. It likewise pertains to spirituality to face the manifold of anxieties, ones own as well as those of others, instead of making anxiety – the fear of life, which is always also the fear of death – taboo, as often happens in our society and in the everyday business of medicine.

5. Communication

Spirituality means communication, communication between humans and God and between humans among themselves. The Spirit brings about and opens up communication. It is the atmosphere in which the communication between doctor and patient takes place. Its takes place *between* doctor, nurse and patient. The Spirit is the between of human communication, connecting the I and thou while at the same time marking them off from one another and distinguishing between them.

6. Spirituality as a Topic of Organizational Theory

Spirituality has not only to do with the conduct and disposition of the individual patient, doctor or nurse. Rather, it also has to do with the culture of a medical or nursing organization. We occasionally speak of the spirit that rules a house. Hence, spirituality is also a topic of organizational theory. Structures, or even the architecture of a house are to some extent objectifications of the spirit. They convey as certain atmosphere, making possible, facilitating or hindering processes of communication. The question of the structures, and of the working and living conditions in a clinic or nursing home, also belongs to the dimension of spirituality. And finally, also numbered here, is the concrete question, which budgets are available for offers of chaplaincy and the corresponding further training and education.

[39] Dietrich Rössler, Der Arzt zwischen Technik und Humanität. Religiöse und ethische Aspekte der Krise im Gesundheitswesen, München 1977, 46.

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