

Essay

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Hostility to Hospitality: Authors' Response

Hostility to Hospitality: Response

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Abstract: This article offers a brief response to constructive criticism of the book featured in this edition of *Spiritual Care*. *Hostility to Hospitality* argues that the role of spirituality within the care of sick patients, despite clear empirical evidence demonstrating its importance, remains deeply contested because of bias against religious communities. Deeply flawed conceptualizations of the nature of religion and the secular camouflage how a society's commitment to immanence functions like a spirituality. A secular framework weakens how spiritual communities can positively influence medical institutions or socialize professional guilds in caring for the whole patient. The diminishment of communities that champion compassion as a chief end, pave a way for hostile economic, technological, and bureaucratic forces to suppress our ability to fully care for patients in body and soul. Rather than being neutral as purported, the secular structures of medicine manipulate and use pastoral care for its own immanent ends. *Hostility to Hospitality* argues that unless pluralism is embraced, allowing for a diversity of religious communities to influence the structures of medicine, compassionate and holistic care will increasingly become unlikely as impersonal social forces increase.

Keywords: religion, spiritual care, medicine and religion, theology of medicine

Zusammenfassung: Der vorliegende Artikel bietet eine Response auf die Beiträge, die sich in dieser Ausgabe von SPIRITUAL CARE kritisch mit dem Buch *Hostility to Hospitality* auseinandergesetzt haben. Das Buch argumentiert, dass die Rolle der Spiritualität in der Betreuung von Patienten – trotz empirischer Evidenz, welche ihre Wichtigkeit belegt – stark umstritten bleibt, da es eine Voreingenommenheit gegenüber gewissen religiösen Gemeinschaften gibt. Höchst problematische Konzeptualisierungen von Religion und Säkularität verschleiern den Umstand,

dass gesellschaftliche Verpflichtungen zu einer weltlich-immanenten Weltanschauung selbst wie eine Art der Spiritualität funktionieren. Ein säkularer Rahmen schwächt die Art und Weise, wie spirituelle Gemeinschaften medizinische Institutionen positiv beeinflussen oder professionelle Vereinigungen in einer ganzheitlichen Betreuung von Patienten sozialisiert werden können. Die Geringschätzung von Gemeinschaften, welche Mitgefühl als ihre Hauptaufgabe sehen, ebnet den Weg für feindselige wirtschaftliche, technologische und bürokratische Kräfte, welche unsere Fähigkeit behindern, uns uneingeschränkt um die körperlichen und seelischen Belange von Patienten zu kümmern. Statt neutral zu sein, wie sie sich selbst gerne darstellen, manipulieren und instrumentalisieren säkulare Strukturen der Medizin die Seelsorge für ihre eigenen, immanenten Zwecke. *Hostility to Hospitality* argumentiert, dass eine einfühlsame und ganzheitliche Versorgung unwahrscheinlicher wird und unpersönliche soziale Kräfte hervortreten werden, wenn nicht ein stärkerer weltanschaulicher Pluralismus Einzug hält, der dazu führt, dass eine Vielfalt an religiösen Gemeinschaften die Strukturen der Medizin beeinflussen.

Schlüsselwörter: Religion, Spiritual Care, Medizin und Religion, Theologie der Medizin

One can hardly imagine anything more professionally satisfying than the completion of a book that requires over ten years of research and writing. Perhaps only our kind publishers at Oxford University Press were more pleased and relieved given our countless delays. The writing of *Hostility to Hospitality: Spirituality and Professional Socialization within Medicine* was painstaking, particularly as we are so intertwined in the fabric of medicine that exploring its interwoven cultural layers and embarking to see beyond it, was an experience not unlike a dog chasing its tail. The harder one pursues, the faster the tail flees. But now, at rest and with the book in the hands of others, there is a newfound and greater professional satisfaction – that of seeing others grapple with the book's argument. Whether in approbation or opprobrium, the engagement by thoughtful persons offering varying perspectives and

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new ideas chews the cud of what is inevitably fibrous and incomplete to become potentially more nourishing. This is achieved in the probing reflections of David Neuhold, Guy Jobin, Simon Peng-Keller, Fabian Winiger, and Eckhard Frick.

David Neuhold provides a succinct and comprehensive introduction to the book's central thesis and structure. He offers helpful critiques naming in more particularity how our grounding in the Christian tradition influences our approach, such as within our reflections on history and to a critique of immanence within medicine, a point also variably highlighted by the other contributors. Guy Jobin provides a contextual and theological synthesis, including juxtaposing the theology of Ghislain Lafont to shine light on the book's argument. Jobin views the beginning of the book's argument as prophetic – as it names discontinuities between medicine and spirituality/religion such as the neglect of spirituality within medical practice. And yet, he ultimately views the book's stance as sapiential given that much of the argument seeks to elucidate places of similarity and analogy between medicine and spirituality/religion to draw them together into unity. However, he raises what is viewed as a potentially irreconcilable point of discontinuity – while health has disease, spirituality, in Jobin's view, does not have an analogous pathology. This view is certainly debatable, but whatever the stance, influences how one might consider synthesizing spirituality and the practice of medicine. Simon Peng-Keller's commentary shines further light on the spiritual care models governing the book's line of reasoning and the current landscape of spiritual care within medicine – that of spiritual care skeptics, spiritual generalists and religious particularists, our own argument being dominated by the latter view. Peng-Keller helpfully points out that though spiritual generalists dominate the thrust of spiritual care integration and professionalization, professionalization of chaplaincy need not be linked to the generalist approach. He argues instead that chaplaincy should as part of its process of professionalization move toward pluralism without false pretenses of neutrality, going so far to name this an “ethical question of transparency.” Fabian Winiger turns attention to issues of definitions, arguing that the concept of “chief love” stems from monotheistic assumptions and fails to capture many spiritual traditions such as Buddhism, governed by the goal of detachment, or Hinduism, governed by devotion to a multitude of gods. He critiques structural pluralism, doubting that holders of various traditions can come to agreement as to a shared vision for medicine. Interestingly and more hopefully, he presents what is essentially an example of a successful structurally pluralist approach in the World

Health Organizations's cross-cultural development of the module “spirituality, religiousness, and personal beliefs.” Finally, Eckhard Frick contrasts the US and European healthcare systems, naming points of key difference relevant to spiritual care, such as the connection of some US healthcare institutions to religious traditions. Frick then goes on to point out places of similarity, particularly in regard to secular medicine's spirituality of immanence, providing perspective on how this spirituality of immanence influences European medicine and advocating for the welcoming of variegated spiritualities as part of his forthcoming spiritual care model. Our esteemed contributors have presented a vast array of new ideas and critiques, rendering any comprehensive engagement impossible, as much as we would enjoy that fuller conversation. Instead, we have chosen three topics that have been raised by multiple authors, and attempted to address them thematically.

1 The role of religious viewpoints

The first theme is the frequently noted point of our own religious commitments and their influence on the book's perspectives and arguments. Of course, we named our religious commitments in our introduction for this very reason – we do not pretend to be that elusive, neutral observer which too often is the pretense in scholarship. We all have biases, both in making arguments or in critiquing them. If everyone names the traditions that influence them most deeply, a logical consequence of structural pluralism (a concept we argue for in Chapter 15), then it becomes plausible to understand the actual relationship between medicine and spirituality. Far too many in secular medicine have faith that they operate outside of a tradition, which is part of the fundamental problem. Then there are those operating in theology or in pastoral care, and they too suggest that they are somehow above or outside of a theological tradition. Claims of neutrality have “stacked the deck” against any real dialogue between medicine and faith. Our argument offers a pathway that allows for a different way of caring for holistic care of patients, and a different way of doing rigorous “public” theological reflection.

Moreover, if the goal is full characterization of perspective and bias, however, the critique did not go far enough. For example, T. A. Balboni grew up in a secular home and was trained in thoroughly secular academic settings. Arguably, Dr. Balboni's “native tongue” is irreligious and secular, though she has spent a good portion of adulthood within the Christian tradition. Hence, though

quite fluent in the “Christian tradition”, if there is such a monolithic thing, she speaks it with a thick, secular drawl. This indeed is a critical perspective that brought to bear on the book’s arguments. We could drill down further of course in naming perspective and bias. How about the one laid bare as soon as one glances at the front cover of our book – the fact that the authors are married? Certainly partnership in marriage is a perspective that has bearing and unique biases shaping this book’s goal – one from medicine and the other from theology. Professional partnerships between married couples in academia, we have found, are common. But what is uncommon is for those partners to share the same surname, such that often the partnership remains largely hidden. We are not advocating for others to adopt our approach, but name this simply to point out that we have chosen a shared surname as an illustration of our unity, which is a central perspective relevant to the content of our book, and also as part of a shared personal and professional value for transparency. And yet some critical comments focus solely on Christian presuppositions, as if this is the primary source of perspective that we have brought to bear in this work. This risks flattening the book’s argument as solely comprised of “Christian” ideas rooted in a “Christian” history and has the potential to create what may be unnecessary barriers to speak into a variety of settings. Of course, the book is indeed influenced by Judeo-Christian history and perspectives which should be recognized soberly and contrasted with those of other traditions. But the book is also centrally influenced by two married people sharing life, raising children, and working together in the context of interest. It is influenced by living and passing regularly between two worlds – that of secular medicine and that of a religious community. It is influenced by living among others – we live in a Christian community of trainees in secular, academic health care – struggling and flourishing with the selfsame dichotomies. These too are critical perspectives, and when we name them, though our differences from others grows greater (even in comparison to other ‘Christians’), strangely these contextual realities that were truly the wellspring of this book may render our arguments more relatable to different settings. Perhaps our commentators also live in a setting of passing between secular and religious spaces? Perhaps Buddhist, Muslim, Hindu, and Naturopath friends, among others, also share in that experience? These are points of unity, points of mutual connection and understanding which can push us beyond what can appear unnecessarily divisive broad generalizations.

This is a minor point of clarification, but some also alluded to the greater influence of religion on medicine in

the United States as compared to other healthcare settings, particularly in comparison to healthcare settings in Europe. There are some institutions that have retained their religious identity in the U.S., but that is the exception and not the rule. A great deal of U.S. health care institutions are thoroughly secular, even if they have a name that might suggest otherwise, which is typically a vestige of a distant and long forgotten past. This is particularly the case for academic medical settings.

2 Defining spirituality

The next theme of comments regards definitions, particularly that of the conception of spirituality as a ‘chief love’. Language is a tool, but tools can fail our purposes or, perhaps more commonly, we simply use them improperly. The adjective “chief” is to denote as central, but it is not meant to denote a numerical value, whether zero, one, or many. Furthermore, love or affection is meant to denote something of central or supreme value, such that the individual’s perspectives and actions are shaped by it. It is not simple emotions or desire (which is how love is often understood). Hence, for the Buddhist, there is a chief, or centering, “love,” and that is the orienting purpose to empty oneself, to remove all desire. In contrast among some in Hinduism, a functional chief love may be centered on multiple gods, each with varying roles in regard to that person, forming a complex system of centering influence. We recognize that these traditions may not use the term “love” as an orientating principle, but that our concept of “chief love” is dynamically equivalent to the concepts that underlay other diverse traditions, whether “Amazonian spirituality” or a spirituality associated with “Amazon.com.” Whether one uses the term ‘chief love’ or ‘telos’ or some other term, in function we contend that part of what it means to be human is to be oriented toward a center or centers of deepest commitment.

Furthermore, our colleagues provided some helpful perspectives on our critiques of immanence. One colleague expressed concern that our argument did not sufficiently clarify and deem that a spirituality of immanence is a tradition. We think this point is implied throughout the book (e.g., pages 225, 239, 274, 301, etc.), but it could have been said more plainly. Our argument assumes that a spirituality of immanence is a tradition, which in a structurally pluralist model, has its place alongside other traditions in offering spiritual care. However, the immanent tradition should not hold a monopoly over medicine’s structures or the manner in which spiritual care is conceptualized and provided.

3 Practicality

Finally, commentators often highlighted the sheer practical difficulty in the proposed structural pluralist model to shape spirituality within the practice of medicine. Of course the intent of this portion of the book was a proposition to be further refined for application, not a prescription or one-size-fits-all approach. In that vein, the commentators have contributed to that refinement process as they have described both opportunities and pitfalls. We agree that this book's proposition particularly requires consideration and input by those coming from other religious and cultural contexts, and would add that this shaping process should also happen in a variety of healthcare settings. The practical application of the structural pluralist model must happen in the context of lived, everyday communities. The manifestations of structurally pluralist models of spiritual communities forming the embrace of spirituality by a healthcare institution will vary widely depending on whether located in Lahore, Pakistan or Boca Raton, USA.

We are humbled and grateful for the sifting *Hostility to Hospitality* has received in the insightful comments rendered in this dedicated issue. While we thought that our

contribution to the questions of medicine and spirituality should take the form of a thick academic account, it is not our intention for the book to remain in ivory towers of thought. Rather the hope is that it will return from whence it came – from the everyday, typified in a mundane married couple travelling regularly between the disparate worlds of secular medicine and the Christian tradition. Our hope is that through the continued shaping of these ideas by colleagues from varying contexts, cultures, and traditions, it will be a shared endeavor to open once-closed doors to spirituality within medicine. In that sense, the book is at first an invitation to our home, but then in sending it out, a call upon others in their shaping of its ideas to do the same. In opening those doors of welcome, we will together transform hostility to hospitality.

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