PART ONE

SIX SPIRITUAL INTERESTS WITHIN HEALTH CARE

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A Spiritually Interested Culture

Despite frequent comments about secularization in western society and a decrease in church membership, there is widespread evidence of a hunger for the spiritual. . . . [This] interest in spirituality is certainly not confined to churchgoers or those commonly identified as religious people.[1]

1. Philip Sheldrake, *Spirituality and History* (New York: Crossroad, 1992), p. 1.

As John Coleman notes, "It is quite clear that there is, palpably, a large and exploding marketplace for spirituality in America."[2] Other cultural commentators have noted the same emerging spiritual interest, an interest that spans generations.[3] It is present among the elderly,[4] the baby boomers,[5] generation X,[6] and even children.[7] This widespread interest suggests that the image of America is shifting from a secular culture to a spiritually interested culture.

Why is there an exploding interest in the spiritual? Some commentators point to positive influences: contact with Eastern religions and spiritual philosophies, an increase in scientific knowledge that leads into mystery rather than away from it, a mind-boggling awareness of the reach of the cosmos, a deepened sense of our symbiotic relationship with the

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2. John A. Coleman, S.J., "Exploding Spiritualities: Their Social Causes, Social Location and Social Divide," *Christian Spirituality Bulletin* (Spring 1997).

3. Phyllis A. Tickle, *Rediscovering the Sacred: Spirituality in America* (New York: Crossroad, 1995); Robert Wuthnow, *After Heaven: Spirituality in America Since the 1950s* (Berkeley: University of California Press, 1998); Don Lattin and Richard Cimino, *Shopping for Faith: American Religion in the New Millennium*; J. Naisbitt and P. Aburdene, *Megatrends 2000* (New York: William Morrow, 1988); Paul Ray, *The Integral Culture Survey: A Study of the Emergence of Transformational Values in America*, (Institute of Noetic Sciences, 1998); Robert K.C. Forman, Kathryn Davision, and Susan Jorgensen, *Grassroots Spirituality* (The Forge Institute).

4. Zalman Schachter-Shalomi and Ronald Miller, *From Age-ing to Sage-ing: A Profound New Vision of Growing Older* (New York: Warner Books, 1995).

5. Wade Clark Roof, A Generation of Seekers: *The Spiritual Journeys of the Baby Boom Generation* (San Francisco: HarperSanFrancisco, 1993).

6. Robert Ludwig, *Reconstructing Catholicism for a New Generation* (New York: Crossroad, 1996); Tom Beaudoin, *Virtual Faith: The Irreverent Spiritual Quest of Generation X* (San Francisco: Jossey-Bass Publishers, 1998).

7. Edwin Robinson, *The Original Vision* (Manchester College, Oxford: The Religious Experience Research Unit, 1977); Robert Coles, *The Spiritual Life of Children* (Boston: Houghton Mifflin, 1990).

earth, a commitment to social justice and the well-being of all people. Welcoming and nourishing these experiences and insights create a spiritual yearning, a intense desire to "be in life in a new way." Diarmuid O Murchu names this yearning as a quest "to reclaim the deep, primal sacred story of our evolving universe; of planet Earth as our cosmic home; in the diverse and magnificent array of life-forms around us; in the largely untold story of the evolution of spiritual consciousness within humanity itself, and, finally, in the contemporary desire to create a one-world family characterized by love, justice, peace, and liberation."[8] Most people could add to this list both personal experiences and other cultural developments that stimulate interest in the spiritual.

Other cultural observers see the interest in the spiritual as a response to negative experiences. People are reaching for the spiritual as a way to reclaim dignity and purpose in the midst of fears, moral failures, and a general sense that "things are out of control." According to these observers, the underlying energy of contemporary spiritual interest is the ambiguous and destructive events of the twentieth century: the ongoing horrors of wars that have demonstrated an increased capacity for violence, runaway technology that dehumanizes people even as it claims to advance their causes, economic uncertainty, terrorism, viral epidemics, increasing disparity between the rich and the poor, moral laxity among the leaders of the world, pervasive narcissism and restlessness, the frantic pace of life, the debunking of the myth of progress, the bankruptcy of a secular point of view, etc.

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8. Diarmuid O Murchu, *Reclaiming Spirituality* (New York: Crossroad, 1998), p. ix.

Frances Vaughan notes, "In recent travels all over the world I have seen new forms of spirituality appearing everywhere. As people become more conscious that problems such as pollution, overpopulation, war, depletion of resources and the devastation of the planet are human caused, there is a growing awareness of the urgent need for changing human consciousness and behavior."[9] Most people could add to this list both personal experiences and other cultural developments that profoundly worry them, that make them pause and consider the possibility of the spiritual.

Traditionally, both positive and negative experiences have awakened people to the spiritual. Thus, in any given individual, the interest in the spiritual may emerge both as a recoiling response to certain negative experiences and as an inclination to pursue certain positive experiences. The positive and negative work together to stimulate the interest.

As Philip Sheldrake noted in the quotation that opened this chapter, this spiritual interest can be found in the culture at large. It is not confined to churches, synagogues, mosques, and temples. Organized religion may be the home of the spiritual, but it is not its exclusive dwelling place. Interest in the spiritual is emerging in the corporate world; in the athletic sphere; in areas of social justice; in the struggles of community organizing; in the ecological, feminist and elder movements[10]; and, of course, in health care. This widespread interest in the spiritual has spurred some commentators to

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9. Frances Vaughan, *Shadows of the Sacred* (Wheaton, Il: Quest Books, 1995), p. xv.

10. Confer Roger S. Gottlieb, ed., *A New Creation: America's Contemporary Spiritual Voices* (New York: Crossroad, 1990); Peter Van Ness, ed., *Spirituality and the Secular Quest* (New York: Crossroad, 1996).

understand the spiritual search as an anthropological constant. It is a human birthright, part of the human condition. It can be ignored and dismissed, but it cannot be eradicated. In the past, this spiritual search, which is a potential in every person, was pursued by only a few or restricted to the elite of organized religions. Today many are interested—even if they are interested only on their own terms.

This larger cultural interest in the spiritual is the context for the spiritual interests that are emerging within health care. Health care and the spiritual have always been closely related, in part because health care attends to people as they suffer, and suffering is often a time of spiritual invitation. In times of sickness, people reevaluate their lives and ask questions about what is ultimate and true. By its very nature, health care lives at this juncture of human suffering and spiritual search. Also, many health care organizations were founded by communities of faith and today remain religiously affiliated, so naturally they combined medical and spiritual care, refusing to restrict their attention to only physical and mental health. Today, however, these reasons do not provide a complete explanation for the interest in the connection between health care and spirituality. The larger cultural interest has to be taken into account as the context that encourages the specific spiritual interests of health care. Daniel Sulmasy says it succinctly, "The same spiritual hungers that are affecting the rest of society are affecting health care professionals as well."[11]

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11. Daniel Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals* (New York: Paulist, 1997), p. 8.

Whatever the causes of the current hunger for the spiritual, it should be stressed that it is just that—a hunger. It is an interest, an inclination, a sense that the spiritual may be a missing piece. It is an inchoate yearning, a formless reaching out for something that is not explicitly known but sensed as crucial.[12] It is talked about as a desire ("In brief, according to our respondents, spirituality is the basic desire to find ultimate meaning and purpose in one's life and to live an integrated life.[13]) or a need ("The most important thing in defining spirit is the recognition that spirit is an essential need of human nature"[14]). The cultural interest in the spiritual and the way that interest manifests itself in different spheres is a beginning, an initial awakening, a first step on a spiritual journey that has the reputation of taking people places they never dreamed of going.

This spiritual longing naturally unfolds into a spiritual search. People become seekers and create a market for spiritualities. Spiritualities are sets of beliefs, stories, and practices that open up and develop the spiritual interest. They show how the hunger can be fed, how the interest can be pursued. Therefore, the quest for spiritualities is energized

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12. For the dangers involved in the combination of a spiritually interested culture and a spiritually illiterate culture, see John A. Coleman, S.J., "Exploding Spiritualities: Their Social Causes, Social Location and Social Divide," *Christian Spirituality Bulletin* (Spring 1997). Also, for a profound critique of much of what is passing for spiritual interest, see Ken Wilber, *Eye to Eye: The Quest for the New Paradigm* (Boston: Shambhala, 1990), especially Chapter 8, "The Pre-Trans Fallacy," and *One Taste* (Boston: Shambhala, 1999), pp. 111–112.

13. Ian I. Mitroff and Elizabeth A. Denton, *A Spiritual Audit of Corporate America* (San Francisco: Jossey-Bass Publishers, 1999) p. xv.

14. Rachel Naomi Remen, "On Defining Spirit," *Noetic Sciences Review* (1998): 64.

by the intuitive interest in the spiritual, the desire to follow what at first is only a clue.

This distinction between spiritual interest and spiritualities is important. Spiritual interest always emerges out of particular situations. It has definite expectations, even if those expectations are difficult to articulate. It knows what it wants and what it does not want. In other words, spiritual interest is discriminating; the spiritual hunger is looking for a specific menu. Spiritual interest decides which spiritualities or parts of spiritualities will be adopted and which will not be pursued.

For example, many people immersed in the demands of family and work often feel they are "losing themselves." Their inner sense is that they chop a lot of trees, but they have lost sight of the forest. They are making excellent time, but they have forgotten where they are going. Therefore, they are looking for ways to remember who they are as they do what has to be done. This is their spiritual interest—how to stay in touch with the deeper levels of themselves as they engage the tasks of work and family.

Often these people encounter spiritualities that have been developed in monastic settings.[15] This initial meeting seldom goes well. It is difficult to see how spiritual practices such as silence, fasting, and regular prayer times can fit into realities of life in the world. Also, it is not clear how these practices respond to the particular shape of a spiritual interest. How do they help struggling people stay focused in the midst

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15. See Gregory F. Augustine Pierce, "Disciplines for a Spirituality of Work," *Origins 32* (January 1999), p. 28.

of the fray? This spirituality does not seem to be sufficiently correlated to the spiritual interest. Perhaps with further exploration this surface mismatch will give way to deeper levels of connection. If this does not happen, the result is, on one hand, a spiritual interest that is not pursued and runs the risk of withering and, on the other hand, a spirituality that cannot adapt to new and challenging situations.[16]

Therefore, it is helpful to inquire more deeply into the spiritual interest. How is the spiritual interest being articulated? What is the context that makes the interest understandable? What is hoped for if this interest is pursued? The answers to these questions determine the shape of the spiritual interest and the exact way it opens to further explorations of the spiritual through specific spiritualities.

The Spiritual Interest and Other Interests

There is a particular need to explore the shape of the spiritual interest within health care as it interacts with other interests. Since health care is not one thing but a confluence of many factors, the spiritual interest will be influenced by other interests—by medical practice, organizational and business concerns, economic realities, governmental regulations,

16. The emphasis here is how the spiritual interest becomes a principle of discernment, judging the relevance of existing spiritualities. However, spiritualities—developed ways of thinking and behaving in relationship to the spiritual—also judge spiritual interests. If a spirituality is to have a contemporary audience, it must take into account the particular shape of a spiritual interest. But that does not mean it has to capitulate to it. It can "talk back," showing the inadequacy of the interest or some of its dubious assumptions. The interest has to be honored; it does not have to be worshiped. Matching spiritual interests and spiritualities entails an ongoing dialogue with modifications on both sides.

and insurance practices. The spiritual interest within health care is not pure. It is not emerging from the center of a religious tradition explicitly concerned with the worship of God and the salvation of souls. It is emerging in a workplace. Therefore, it is an interest mixed with other interests.

The language in which the spiritual interest is expressed often reflects this mix of interests.

> "Introducing a spiritual screening tool is one way of enhancing customer satisfaction."

> "Marketing our faith-based nature will probably increase revenues."

> "If we can get the numbers to prove spiritual care decreases hospital stays, we might convince HMOs to pay for it."

> "I'm not sure I believe in prayer, but the data says it helps, so I encourage my patients to pray."

> "I would like to attend to the whole person as our mission says. Even talk some faith talk. But with the decrease in nursing staff, I have too much basic nursing stuff to do. The system works against our efforts at spiritual care."

The spiritual interest is shaped by all the other interests that pervade health care.

Placing the spiritual interest within this complex of concerns does not mean it becomes a mere instrument, a tool of

other purposes, a means to other goals. It is not reduced to a strategy. Harold Koenig makes this point with regard to the mushrooming data on the beneficial effects of religion and spirituality on physical and mental health.

> Becoming religious, only in order to gain positive effects on health, will probably not work very well. Research has shown that persons who use religion as a means to an end do not experience the psychological benefits of religious practice. Rather it is those who involve themselves in religion as an end in itself (i.e., persons with intrinsic faith) who are more likely to experience mental health, greater life satisfaction, and less worry and anxiety.[17]

In a quantitative and qualitative study of business executives, Ian Mitroff and Elizabeth Denton point out the same paradox.

> They (business executives) believed that spirituality is one of the most important determinants of organizational performance. They also believed that people who are more highly developed spiritually achieve better results. In this sense, spirituality may well be the ultimate competitive advantage. However, herein lies a fundamental paradox: those who practice spirituality in order to achieve better corporate results undermine both its practice and its ultimate benefits. To reap the positive benefits of spirituality, it must be practiced for

17. Harold G.Koenig, *Is Religion Good For Your Health? The Effects of Religion on Physical and Mental Health* (New York: Haworth Pastoral Press 1997), p. 126.

its own sake. If one practices spirituality without regard to profits, then greater profits can result.[18]

The spiritual coexists with multiple other interests. It interacts with those interests, and those interests may even be furthered by a person becoming more spiritually developed.[19] However, the spiritual is not subservient to the other interests. It is an end in itself.

Although the spiritual is not the servant of organizational and economic concerns, it *is* a companion. In the environment of health care, it may be related to holistic care and increased patient satisfaction, or it may be pushed in a new way into the measurement game, documenting its results in a way that is proper to its particular realm and activity, or it may even enter into how performance excellence is evaluated. Those who think this mixing of spiritual interest with other interests contaminates the spiritual will not be happy. They will attempt to strip away the organizational and financial contexts so that "pure spirituality" can emerge. Those who think this mixture condition obscures the real goals of the health care business will not be happy either. They will attempt to compartmentalize the spiritual and push it to the margins, move it off the organizational chart and connect it with an easily erasable dotted line. Nevertheless, the fact remains that the spiritual interest and the financial and or-

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18. Mitroff and Denton, *A Spiritual Audit*, xviii.

19. It should be noted, even insisted upon, that pursuing spiritual development often leads people far away from the desire for profits. What looks like a subtle and paradoxical strategy for performance excellence becomes a whole new understanding of what "performance" and "excellence" really mean. Spiritually developed people often become subversive of "business as usual."

ganizational interests live in the same house. They are best explored in terms of how they interact with one another.

Six Spiritual Interests Within Health Care

The interest in the spiritual within health care is actually a matter of many interests. The interest arises in different areas and is shaped by the dynamics of that area. Although it is impossible to name all the areas and the diverse ways the spiritual interest is articulated, it is helpful to distinguish six areas. It is also important not to let these distinctions slip into separations. These areas are intimately connected to one another. Considering them one at a time can deepen the appreciation of each of them, but it should not lead to isolating them from one another. Together they form a network of spiritual interests within health care.

The first and foundational interest in health care inevitably arises in the experience of the patients. In particular, how they and their friends and families face and deal with suffering, loss, and limit. It is important to begin with patients from their own internal point of view. This is their time to enter more deeply into the mystery of health and sickness, to know the truth of W.H. Auden's poem.

> About suffering they were never wrong,
> The Old Masters: how well they
> understood
> Its human position; how it takes place
> While someone else is eating or opening a
> window or just walking dully along.[20]

20. *W.H. Auden: Collected Poems* (New York Books Vintage International, 1976).

As it is the patient's "turn," so eventually it will be everybody's turn. We are all patients-in-waiting. As patients reach for both medical and spiritual resources, they create the foundational spiritual interest within health care. Every other spiritual interest is in some way related to this first and foremost reality—the human person in the struggles of health and illness.

A second spiritual interest arises among the caregivers—physicians, nurses, social workers, family, friends, and others. Their interest overlaps with the patient's. They want to know how to integrate spirituality into patient care. This interest comes from first-hand experience, but it is also generated by recent research. There is a great deal of interest in measuring the effects of religion and spirituality on physical and mental health. Since medical practice has the reputation of paying attention to evidence, these emerging data have implications for medical education and medical care.

Third, the inevitable flipside of dealing with the spiritual interests of the patient, whether from the patient or caregiver perspective, is to focus on the spiritual interests of the caregivers themselves. Some spiritual teachers would contend that the desire to be open to the spiritual perceptions and questions of another presupposes some conscious contact with one's own spiritual search. Perhaps this has always been part of the inner, motivational world of many caregivers. Now, however, many are asking that it come forward in an explicit way. If they pursue it, caregivers begin to walk a spiritual path, personally developing as they care for others.

The fourth area of spiritual interest emerges among chaplains and pastoral care providers. Helping patients spiritually has always been the responsibility of the pastoral care

experiences put people on the threshold of mystery, a space where, Antonio Machado writes poetically, the soul stays awake, "its eyes wide open/ far off things, and listens/ at the shores of the great silence."[23] In discussing religion, Kenneth Pargament makes the same point.

> Religion generally helps people appreciate what they themselves cannot control. It highlights the limitations of material goods, personal desires, and individual lives. Not only that, it offers a way to come to grip with these limitations . . . Thus it may not be too much of an exaggeration to say that an appreciation for the limits of human agency lies at the heart of religion.[24]

Patients are interested in the spiritual because, simply by being patients, they become aware of loss and limit. They find themselves, often against their wills, listening at the "shores of the great silence."

A number of years ago I was working with older Americans on their spiritual development. The assumption was that even in the midst of physical, mental, and social losses, there may be the possibility of spiritual development. Thus, part of the program involved experimenting with different spiritual exercises. One of these exercises asked the participants to remember three times during the week that they were "children of God" or "made in the image of God." This is a foun-

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23. Antonio Machado, "Is My Soul Asleep?" in Robert Bly, *The Soul Is Here For Its Own Joy* (Hopewell, N.J.: Ecco Press, 1995).

24. Kenneth Paragment, *The Psychology of Religion and Coping* (Guilford Press, 1997), p. 8.

dational spiritual truth but one that is easily forgotten. The next week they were asked when they remembered this spiritual truth. One woman quietly volunteered, "While I was waiting for the doctor." Everyone nodded. Being a patient pushes our awareness toward the spiritual.

For many patients, this openness to the spiritual is an overt plea for help. It is a search for a cure that doctors may not be able to accomplish or may only be able to accomplish with divine help. It is an attempt to bring the spiritual into the situation in the hope that it will contribute to successful physical and mental outcomes. At other times the openness to the spiritual comes about as patients realize the inevitability of loss and limit. They ask the questions, "How will I "do" with this limit? How will I relate to this loss?" Such questions are reminiscent of Dostoevski's remark, "I pray I may be worthy of my sufferings." Some observers have said that on entering patienthood there is a centrifugal force. So much seems to be moving away from the center of the person who has become a patient. What is sought is a counter force, a centripetal movement that brings things back to the center of the person. The spiritual embodies such a centripetal power. It reestablishes the center of the person who is beset by loss and limit.

John O'Donohue tells the story of a woman facing limit and loss who, with the help of a priest, reestablishes her center, and counters the centrifugal movement with a spiritual centripetal response.

> A friend of mine went to the hospital to have a hysterectomy. A priest friend came to visit her on the evening before her operation. She was anxious and vulnerable. He sat down and

they began to talk. He suggested to her that she have a conversation with her womb. To talk to her womb as a friend. She could thank her womb for making her a mother. To thank it for all her different children who had begun there. The body, mind and spirit of each child had been tenderly formed in that kind darkness. She could remember the different times in her life when she was acutely aware of her own presence, power and vulnerability as a mother. To thank her womb for the gifts and the difficulties. To explain to it how it had become ill and that it was necessary for her continuing life as a mother to have it removed. She was to undertake this intimate ritual of leave-taking before the surgeons came in the morning to take her womb away. She did this ritual with tenderness and warmth of heart. The operation was a great success. Her conversation with her womb changed the whole experience. The power was not with the doctors or the hospital. The experience did not have the clinical, short-circuit edge of so much mechanical and anonymous hospital efficiency. The experience became totally her own, the leave-taking of her own womb.[25]

Patients are interested in the spiritual because it may hold the secret to how they can relate to their own leave-takings, even the leave-taking of death.

However, there is more. Religious traditions universally suggest that suffering can be a spiritual path. It can take us into the land of Spirit and teach us truths to which we would

25. John O'Donohue, *Eternal Echoes: Exploring Our Hunger To Belong* (New York: Bantam, 1998), pp. 179–80.

not otherwise have access. This is the message John Updike brought back from his fever.

> I have brought back a good
> message from the land of 102 degrees:
> God exists.
> I had seriously doubted it before;
> but the bedposts spoke of it with utmost
> confidence,
> the threads in my blanket took it for granted,
> the tree outside the window dismissed all
> complaints,
> and I have not slept so justly for years.
> It is hard, now, to convey
> how emblematically appearances sat
> upon the membranes of my consciousness;
> but it is truth long known,
> that some secrets are hidden from health.[26]

The "secrets that are hidden from health" concern the spiritual grounding of life. Updike's sickness became an invitation to explore this previously hidden truth—the mundane obviousness of God. Sickness is a chaotic event on all levels, disturbing physical, psychological, social, and spiritual equilibrium. Yet in many situations, the spiritual disturbance is an invitation to growth, a challenge to greater spiritual realization.

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26. John Updike, *Collected Poems, 1953–1993* (New York: Knopf, 1993), p. 28.

This seems to be the case with Joan Didion.[27] In her autobiographical essay "In Bed", she unfolds her ongoing relationship to her migraine headaches. She has taken up any number of attitudes toward them. She has denied them, fought them, and tried to understand them. But now she thinks she is "wise in its ways."

> I no longer fight it. I lie down and let it happen. At first every small apprehension is magnified, every anxiety a pounding terror. Then the pain comes, and I concentrate only on that. Right there is the usefulness of migraine, there in that imposed yoga, the concentration on the pain. For when the pain recedes, ten or twelve hours later, everything goes with it, all the hidden resentments, all the vain anxieties. The migraine has acted as a circuit breaker, and the fuses have emerged intact. There is a pleasant convalescent euphoria. I open the windows and feel the air, eat gratefully, sleep well. I notice the particular nature of a flower in a glass on the stair landing. I count my blessings.

The sickness has become a yoga, purging her and bringing her to gratitude, a gratitude that might not be available without the discipline of the migraine.

One of the foremost spiritual invitations that arises from sickness is to reconcile from the heart. Sickness forces a scrutiny, an inward glance into the heart to discern what must be done. It encourages a process of prioritization. What is important? The result of this "taking stock" is often the re-

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27. Joan Didion, *The White Album* (New York: Simon and Schuster, 1979) p. 172.

alization that words of love have not been spoken. Too much has gone unsaid. Too much has been taken for granted. Under the pressure of illness words of love are spoken, sometimes initiated by the sick and sometimes by the well. These words of love from the heart reestablish broken relationships and revitalize dormant relationships. At the prospect of limit and loss, there is an encouragement for people to reach out to one another. Their essential closeness comes to the surface, breaks through silence into speech.

When the spiritual interest of patients is characterized as the ability to relate to loss and limit and the courage to follow loss and limit into profound spiritual realizations, what spiritualities—beliefs, stories, practices—will critique and develop that interest?

Two: The Spiritual Interest of Medical Caregivers in Patients

"Caregivers" is a broad category. It includes doctors, nurses, social workers, family, friends, visitors, and others.[28] Often these people have specific areas of care. Doctors and nurses, for instance, attend to aspects of physical health and illness; social workers attend to various social contexts; family and friends provide emotional and personal support. These different focuses generate a system of referrals whose goal is to give specialized, quality care to the patient.

However, this division of labor is not absolute. Caregivers find themselves in the presence of the whole person. This person of the patient is always the ultimate subject of care

28. Chaplains, congregational clergy, and various ministers of care are certainly caregivers. However, their interest in the spiritual will be considered under the "chaplain" category.

and so what is important to the patient becomes important to the caregiver. The foundational reason for this is that caring for patients means acknowledging and addressing their concerns. Even if the caregiver is a doctor or a nurse, when the patient talks about prayer or God or forgiveness, the conversation is engaged.[29] Daniel Sulmasy thinks that "the fact that religion is important to patients seems to be justification enough" to pursue conversations about spirituality.[30]

Recently, medical caregivers have also found additional reasons for engaging in spiritual conversations with patients. There has been considerable research into the connection between religion, spirituality, and health. A multitude of studies have linked religion and spirituality to specifically medical goals. In general, these studies have shown that religion and spirituality have positive effects on physical and mental health.[31] Although there are methodological questions about this research and ethical questions about its implications, religion and spirituality have become variables in the quest for a better understanding of disease and health.[32]

When religion and spirituality appear on the medical screen in this way, they do so in terms of medical values. These values prize clear definitions, sharp distinctions, and empirical ways to measure results. The exact pathways that religion and spirituality move along to contribute to better

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29. See Constance Harris Sumner, BSN, RN, OCN, "Recognizing and Responding to Spiritual Distress," *AJN* (January 1998).

30. For an extended discussion of this, see Sulmasy, *Healer's* chapter four: "God-Talk at the Bedside."

31. See Koenig, *Is Religion Good for Your Health?* Dale Matthews, M.D. with Connie Clark, *The Faith Factor: Proof of the Healing Power of Prayer* (New York: Viking, 1998).

32. See R.P. Stone, E. Bagiella, T. Powell, "Religion, Spirituality, and Medicine," *The Lancet* (February 1999): 664–67.

health are probed in the hope they can be consistently traveled. This new appreciation of religion and spirituality moves them from an important but concomitant concern to a potential medical resource in the struggle for health.

Many see this inclusion of the spiritual in medical treatment as part of a history of expansion. Once medical care was narrowly focused on the health and disease of the body. Then the mind was included because of the influences of mental states on the entire organism. Then it was recognized that social factors were crucial determinants of health and disease. Finally, the spiritual and its impact have entered into the purview of the medical approach. The result is a more inclusive picture of what makes for health and sickness, a careful attending to the complete person in his or her physical, psychological, social, and spiritual aspects.[33]

This connection between religion, spirituality, and health raises questions about how doctors are educated and what is the scope of the physician-patient relationship. A growing number of medical schools are now finding space in their curriculum for a course on religion and spirituality.[34] Also, some thinkers encourage physicians to support a patient's spiritual and religious beliefs. This support may include spiritual screening,[35] a basic respectfulness and openness to con-

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33. See *Piecing Together the Puzzle: The Future of Health and Health Care in America* (Institute for the Future).

34. Christian M. Puchalski, MD, MS, and David B. Larson, MD, MSPH, "Developing Curricula in Spirituality and Medicine," *Academic Medicine*, 73, no. 9 (September, 1998); Howard Silverman, "Creating a Spirituality Curriculum for Family Practice Residents." *Alternative Therapy 3* (1997): 54–61.

35. From a chaplaincy perspective see "Symposium: Screening for Spiritual Risk" *Chaplaincy Today* 15 (1999).

versations about religion and spirituality, and referrals to people more qualified in the area of spirituality.[36] It may also, under certain circumstances, go beyond these. Physician and patient may engage in a common religious practice, for example, attend a worship service together or pray with one another.

These developments raise many theological and ethical questions. Although spiritual activity may enhance mental and physical health, is that what spirituality is about? Or does the spiritual life have to be pursued in terms of its own goals—a deepened relationship to Spirit—and not in terms of its medical effects? In the immediate past a medical caregiver's faith and spirituality were deep background to his or her practice. Does bringing it to the foreground in a noncoercive way require a new set of skills? What type of knowledge of religion and spirituality is necessary in order to be respectful of a patient's faith? If medical caregivers move in this direction, do they enter the arena of symbolic healing where the inner attitudes and the quality of the relationship between physician and patient are paramount? How are the boundaries of medical disciplines respected as inquiry into spiritual concerns and issues are pursued? Can medical caregivers be sensitive to the spiritual concerns of a patient if they themselves are spiritually unconcerned? Do medical

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36. For the many nuances to this complex issue of physician-patient relationships and conversations about the spiritual, see Larry Vandecreek, "Should Physicians Discuss Spiritual Concerns With Patients?" *Journal of Religion and Health* 38 (Fall 1999). For a number of different perspectives on integrating spirituality into patient care, see *Integrating Spirituality Into Treatment: Resources for Practitioners*, ed. William R. Miller (American Psychological Association, 1999).

caregivers see their practice of medicine as a path of spiritual development for themselves? What ethical and legal questions are involved in this expansion of the medical caregiver's role?

When the spiritual interest of caregivers in patients is characterized as attention to the whole person with a special recognition that the spiritual may have beneficial impact on physical and mental health, what spiritualities—beliefs, stories, practices—will critique and develop the interest?

Three: The Spiritual Interest of Medical Caregivers in Themselves

A question that is often asked in reflection groups of medical caregivers is, Why did you go into health care? The responses vary, but almost all reach beyond the professional into the personal world of relationships and meaning. Some talk about a childhood experience of living in a house with a chronically sick person. Others talk about an experience of being ill and being compassionately cared for by a doctor or nurse. Or they may talk about coming from a family with many nurses and physicians and hearing the same call. Herbert Benson's opinion is frequently confirmed: "physicians often come into medicine to help people because of spiritual beliefs."[37] Often some of these beliefs have to do with themselves. The caregivers see themselves as hearers of a call, a call that arises out of their own talents and desires but also has a transcendent source.

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37. Beth Baker, "The Faith Factor: An Interview with Herbert Benson," *Common Boundary* (July-August 1997): 24.

However, it is difficult to maintain this sense of call. The work of health care professionals is besieged by pressures that turn the call into a career and the career into a job. When we see what we do as a career, we have tapped into achievement motivation. We are intrinsically driven to do excellent work and to be rewarded for it. But the bigger picture is lacking; the outward sense of service has been replaced by an inner drive to become the best and to be known for it. And when our career peaks, what we do is in danger of becoming a job. When we do a job, we do it for still other reasons. We often work at jobs for extrinsic reasons, usually financial considerations. The higher calling has then devolved into a money game. This occupational hazard, the slide from calling to career to job, is an inner movement, an attitudinal shift that often occurs before people are aware of it. They only recognize what has happened in hindsight.

All work faces the temptation to be alienated, to be separated from the deeper levels of the self and reduced to numbing, repetitious activity, to fall into the category of "a job" in which there is only limited investment. However, with the multiple changes in the surface structures of health care delivery, the work of physicians and nurses is under particular pressure, a pressure that puts so much emphasis on the "letter" that it kills the "spirit."

Health care professionals used to be awash in abbreviations and acronyms of their own creation: COPD, MI, PT/PTT, CMV, WNL, CBC, and so forth. Now they are drowning in a new set of abbreviations created by others: HMO, PPO, IPA, RBRVS, PPRC, HCFA, and so forth. Specialists are being made into generalists. Generalists are being made into

> gatekeepers. Hospitals are closing. Practices are being bought. Report cards are being issued. Utilization reviewers scrutinize clinical decisions from a thousand miles away.[38]

It is in this context of increasing clutter and change that many fear something essential is being lost.

If patients are interested spiritually because they have to deal with limit and loss and medical caregivers are interested in patient spirituality because they value holistic approaches and recognize that the spiritual may have beneficial effects on bodily and mental health, then medical caregivers are interested in their own spirituality because they want to maintain or reclaim their sense of vocation. They can do this in many ways. The classic practices of spiritual renewal are retreats, prayer, spiritual reading, and participation in the rituals of a religious tradition. However, these are all activities outside work. What caregivers want is a vocational renewal that will happen in the middle of their work, in their relationships with staff and patients. The same situations that drain them can then become the situations that inspire them.

Relationships are the key. In an interview with selected family practice physicians, the physicians noted that "spirituality was often experienced in the context of relationships with patients."[39] Sulmasy agrees, "The spiritual doctor or nurse or other health care professional is one who enters into relationships of trust with patients: inviting trust, behaving

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38. Sulmasy, *Healer's Calling* 8.

39. Frederic C. Craigie, Jr. and Richard F. Hobbs, III, "Spiritual Perspectives and Practices of Family Physicians With an Expressed Interest in Spirituality," *Family Medicine* (in press).

in a trustworthy manner regardless of whether of not that trust is reciprocated, and trusting in the basic goodness of a world of healing relationships."[40] On one level the relationship of caregiver to cared for is unequal. The caregiver provides services to the patient. However, there are moments when this dynamic is reversed.

A second oncology nurse tell the story of the elderly, poor, Hispanic man, whose cancer was beyond any hope of treatment or remission, who came to the nursing station at the end of the day, "long after the doctors had left." He went to each of the staff members, shaking their hands and thanking them for "treating him like a man." The nurse's comment was that this episode helped her, and challenged her, to remember why she was doing what she was doing.[41]

Within such relationships the spirit is touched and the vocation is renewed.

In a vocation of service and giving, it is the sudden and unexpected receiving that often brings renewal.

You walk the halls of this place, and what do you see from room to room? Most people peer in and see this retarded child or that one. They focus on this particular mannerism or that deformity. I do it too. It's very compelling, that picture.

But one kid flipped me around on that. We were doing

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40. Sulmasy, *Healer's Calling* 31.

41. Frederic Craigie, "The Spirit and Work: Observations About Spirituality and Organizational Life," *Journal of Psychology and Christianity* 18 (1999).

language exercises. And for some godforsaken reason I'd chosen the exchange "How are you?" . . . "I'm doing fine." We'd go back and forth. Well, he was having quite a hard time of it, slurring out. "Iy dluee fie" or some such. "Let's try again, really slowly," I said. "How . . . are . . . you?" And he slurred, "Iy dluee fie." Then he suddenly burst into this wonderful crazy slurry laugh. It was the nuttiest sound we'd ever heard, either of us. He wasn't doing fine at all. Neither was I. We were doing terribly. It was absurd. We just began to howl.

In the midst of that he suddenly gave me this very clear look—the eyes behind the expression. And I had a sudden thought: "My God, he knows more than I'll ever know about all this. He sees the whole situation." At which point he just scrunched up his face like a clown and gave me this wonderful wink.

I was just stunned. All I could see was this incredible sense of the humor of things. It was so deep in him. He just had it all in perspective. And he gave that perspective to me.

When I left him, my head was spinning. I walked down the hall and looked into the other rooms, at kids I'd known, or so I'd thought, for months. It was totally new. I don't quite know how to describe it. In this room I saw courage. In that room I saw joy. Across the hall, patience. In yet another room, such sweetness: a little body who was so continuously filled with love, people would just—"die," I was going to say. "Live," really.

I felt so humbled. I swear I had the impulse to go down on my knees. Here I was, going around giving speech therapy, little lessons, little tips. And what was I receiving back in return? Humanity. Basic humanity. The deepest qualities of a person, deeper than you'd see most anywhere.

What a gift! How much it helped me in my work! In fact it really changed my life. How often can you say that?[42]

The caregiver on one level becomes a receiver on another level. Experiences such as this make people aware of a dynamic flow of spirit that is deeper than the physical categories of sick and well and the social categories of helper and helpee. These experiences renew people in the midst of work and remind them they are engaged in a vocation.

When the spiritual interest of caregivers in themselves is characterized as renewing their original sense of call by finding spiritual substance in their relationships with patients, what spiritualities—beliefs, stories, practices—will critique and develop this interest?

Four: The Spiritual Interest of Chaplains

The spiritual interest of chaplains is a continuation, a nuancing, and an extension of their perennial concern. Although chaplains wear many hats, attending to the spiritual life of patients has always been important.[43] As Gordon J. Hilsman notes, "Chaplains have developed skills to assess and activate people's spiritual resources during difficult times. They have helped people cope, adjust, accept, and integrate loss and change into the evolving fabric of their lives. They

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42. Ram Dass and Paul Gorman, *How Can I Help?* (New York: Knopf, 1985), pp. 140–42.

43. Don S. Browning "Hospital Chaplaincy As Public Ministry," *Second Opinion* 1 (1986). Browning characterizes chaplaincy as a public ministry in the service of health. In pursuit of this value, the chaplains functioned as value-committed cultural anthropologists, negotiators of world views, stimulators of ethical deliberation, and stimulators of spiritual growth.

have listened and prayed with people in distress, teased out grief that needed expression, used rituals for healing, and advocated for better or more appropriate care."[44] This personal presence is the classical role of the chaplain, a task that will always be needed.

The knowledge and skills needed to be present to people in this way were often a combination of psychological dynamics and theological content. On the one hand, it was not enough merely to call upon comforting beliefs or engage in prayer. Faith and religious practice had a goal. They were to open people to the Divine Source. Therefore, what was important was how the beliefs and prayers were functioning in the mind of the patient. The psychological reception of faith convictions and practices had to be considered. Faith, by itself, was only half the picture. On the other hand, a strictly psychological approach was important but insufficient. Attending to the mental and emotional climate of the patient, friends, and family left out the deeper theological level, a level that the experience of illness was inviting into awareness. Therefore, the chaplain's task of being present to people meant bringing together psychological sophistication with theological depth.

The current interest in spirituality develops this partnership of psychology and theology. Spirituality is concerned with consciousness and so taps into psychological considerations. But it is especially concerned about moments of transcendent awareness, and so it incorporates theological depth.

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44. Gordon J. Hilsman, "Competencies of the New (and Some Old) Spiritual Care Work," *Caregiver Journal* 12, (1996): 3.

discovery but a path of spiritual development, a path that is nurtured by the ongoing experiences of their chaplaincy.

One such experience, an experience bursting with spiritual potential, is Doug's tale.

> The group of chaplain residents in our clinical pastoral education center had been asked to present a pastoral event that seemed to be full of meaning and in some way evocative of theological reflection. The event that Doug shared involved a baby who had been stillborn. The parents wanted to have a memorial service in the hospital chapel. Doug tried in vain to get a more experienced chaplain to officiate at the service because he felt he did not know what to do.
>
> When Doug found that he would need to do the service himself, he quickly prepared some things to say. However, when the nurse brought the stillborn baby into the chapel where he and the parents were, Doug found that he could not say what he had planned to say.
>
> "All I could to was stand there and cry," he said.
>
> Not knowing what to expect, Doug was not surprised when the nurse handed him the baby to hold.
>
> "I want you to baptize my baby," the mother said.
>
> Doug nodded, but he saw no water with which to baptize the baby. Almost without thinking, Doug took a tissue, wiped the tears from the eyes of the parents and his own eyes, and touched it to the baby's head and whispered, "Nicole, I baptize you in the name of the Father, Son and Holy Ghost.[46]

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46. Told in John Patton, *From Ministry to Theology* (Nashville, Tenn.: Abingdon Press, 1990), p. 11.

Moving experiences like this that are told in story form have always been grist for personal exploration and theological reflection. The agenda of spiritual development approaches these stories in a complementary but slightly different way.

Spiritual wisdom often points to a level of knowing deeper than the rational and its corresponding dependence on skills that have been previously tested. Doug "backed into" a spiritual way of being present, a way of not-knowing that allowed him to open into Mystery and respond in ways that the moment provided. This experience is a milestone on Doug's spiritual path, a path that will inform and transform his chaplaincy. A focus on the spiritual promises to deepen the process of self discovery through reflection on experience.

Chaplains are interested in the spiritual because it develops trajectories already present in their work. But once the spiritual is attended to and reflected on, it points out new areas and suggests new projects. First, the spiritual is not reserved for the crisis moments of life when the physical or mental collapses. It is meant to enhance total well-being. In other words, it is more than a coping mechanism. It is a factor in maintaining health and preventing disease. This wider understanding of the relationship of the spiritual to health has implications for chaplains. Perhaps they need to be in closer collaboration with congregations, parishes, synagogues, and mosques. Together chaplains and congregational clergy need to reclaim their spiritual heritage in terms of what it offers to the experiences of health and disease.

Second, with the emerging interests in the spiritual within health care, chaplains may have new audiences (or old audiences in a new way). Chaplains are the closest and most accessible spiritual resources in health care organizations. As

medical caregivers and the organization as a whole become spiritually interested in a new way, chaplains will be called upon. Most likely, it will entail working with groups instead of providing one-to-one personal counseling. Also there will be a need for working knowledge of spiritualities and how they can be welcomed and developed in the hustle and bustle of the health care world. Widespread spiritual interest translates into opportunity, and opportunity translates into challenge.

Finally, and perhaps most urgently, chaplains are spiritually interested because it provides a way to relate to the exploding interfaith population. The traditional ways of pastoral care need to be rethought and expanded in the face of Christian, Jewish, Islamic, Hindu, and Buddhist patients and employees. The spiritual, as it is coming to be used, is the broadest category. It is able to acknowledge and appreciate the diverse perspectives of the various religions of the world. In this interfaith world, chaplaincy is often understood as spiritual care. "Spiritual care" reconceptualizes the role of chaplains and lays out a monumental task. How it will be developed is a complex and difficult challenge.

When the spiritual interest of chaplains is characterized as enhancing their psychological and theological care, affirming and deepening their emphasis on self-knowledge, and showing them a way forward in terms of new alliances, new audiences, and new roles, what spiritualities—beliefs, stories, and practices—will develop and critique that interest?

Five: The Spiritual Interest in Organizational Life

The spiritual interest within the organizational life of health care institutions is logically tied to the medical spiritual in-

terest. If the health care organization is committed to deliv-
ering holistic care, a care that encompasses the physical,
mental, social, and spiritual aspects of being human, then it
also should be interested in the physical, mental, social, and
spiritual health of its employees. It would be contradictory
to try to deliver spiritual care in a spiritually uncaring envi-
ronment, to try to give to others what has not been given to
you. Therefore, the organization as a whole must include the
spiritual in how it attends to its employees if it hopes they
will be spiritually sensitive to one another and to the various
clientele they serve. William J. Bazan and Daniel Dwyer note
that "High quality services cannot be delivered by organiza-
tions or people who are not spiritually grounded. . . . Burn-
out distances caregivers from the recipients of their care, and
the entire organization must be committed to employees'
spiritual needs to assist in preventing these negative re-
sponses." The organizational interest in the spiritual well-
being of its employees is part of its mission of holistic care.

In and of itself an organization cannot create people's spiri-
tual beliefs and spiritual sensitivity. But it can be supportive
of the resources that a person brings to work. It can culti-
vate and elicit the spiritual consciousness and motivation that
is already there. The supposition is that people have an es-
sential spiritual aspect and they are encouraged and satisfied
when that side of them is recognized and invited into the
workplace. An organization that is spiritually interested un-
derstands this deeper level of people, what Abraham Maslow
called "the farther reaches of human nature." It searches out
ways to "tap"[47] into it.

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47. See Jard Kass, "Tapping Into Something Greater Than Ourselves," *Spirituality & Health* (Fall, 1996).

The spiritually interested organization uses motivational techniques that go beyond financial incentives and fear of punishment. It cultivates the personal desires to grow intellectually and to create new ways of doing things. Workers are respected not only because respect might contribute to productivity, but also because respect is an abiding characteristic of the organization's identity. It is the way a spiritually interested organization acts. Such an organization also continually keeps in view the larger meaning of services and products. It is not just what workers do but how what they do contributes to society and, even, enters into and extends God's activity in the world. Paradoxically, when ultimate meanings are present, there is increased attention to detail.

Advocate HealthCare, a faith-based organization sponsored by the Evangelical Lutheran Church in America and the United Church of Christ, provides an example of keeping the big picture in view. It recently drafted "Advocate as Faith-based: A Renewed Focus," a document that outlines seven areas where the faith-based nature of Advocate is visible. One area situates the enterprise of health care in the largest possible context:

> Faith-based must include both relatedness to God and responsiveness to the contemporary situation. In other words, there is a transcendent (God-related) aspect to Advocate's identity and an engaged (world-related) aspect.
>
> When we understand ourselves as related to the God, we know that our health care mission does not come primarily from ourselves or even from the immensity of human need. We are listening and responding to a Divine call that is creating passions in us to alleviate, accompany and transform

human suffering. This transcendent aspect of our identity means the major changes of contemporary health care do not totally define us. Who we are is always deeper than what is happening.

When we understand ourselves as engaged, the whole panorama of health care in America comes into view. We are listening and responding to cultural images, societal policies, business concerns, medical knowledge, organizational issues. We realize the Divine call to care is carried out in a limited and often resistant world. This means we must be competent, savvy, entrepreneurial and creative. This engaged aspect of our identity means that struggle is essential to who we are. We are always looking for a better way to mediate Divine care into human health and suffering. We humbly recognize that as a health care system seeking to be faithful to a Divine call, we are in ongoing need of growth and change in order to carry out our mission.[48]

Whenever it is possible, a spiritually interested organization places human effort in an ultimate context.

The organizational interest in the spiritual is concerned not only with the whole person of the employee but with the leader's ability to manage change. Health care in America is a rapidly changing enterprise in a highly competitive marketplace, and leaders must be able to evaluate and respond to these changes. The alternatives are often starkly stated: either be able to learn and adapt or be prepared to disappear. The survivors will be those who navigate the currents and not

48. *Advocate as Faith-based: A Renewed Focus*. (Oakbrook, Il: Advocate Health Care).

those who either ignore or resist them. In this situation, the abilities that are needed go beyond financial management and technical organizational skills. They are rooted in the person of the leaders, in the inner work they have done with themselves.[49] Some of these abilities are connected with spiritual development—capacities for discernment, compassion, commitment, vision, vulnerability, and grief.[50] Spiritually grounded leaders might be what the times demand.

For example, Peter Senge sees personal mastery as a crucial component of a learning organization. He characterizes personal mastery as a discipline of "continually clarifying and deepening our personal vision, of focusing our energies, of developing patience and of seeing reality objectively."[51] Senge acknowledges the roots of this discipline are in the Eastern and Western spiritual traditions. In a similar vein, Alan Briskin sees the key to organizational learning and adaptive behavior as the ability to see the whole.[52] This capacity to see the whole is directly related to the soul and its development. Without the abilities of the soul, organizations are reduced to piecemeal analyses and bumbling interventions. Spiritually developed people have capacities that are needed to survive and flourish in the changing marketplace.[53]

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49. Parker Palmer, *Leading From Within: Reflections On Spirituality and Leadership*.

50. Cf. Gerald A. Arbuckle, S.M., P.H.D., "Mergers in Health Care" *Human Development* 20, no. 2 (Summer, 1999): 42–48.

51. Peter Senge, *The Fifth Discipline: The Art and Practice of the Learning Organization* (New York: Doubleday, 1990), p. 7.

52. Alan Briskin, *The Stirring of Soul in the Workplace* (Berrett-Koehler, Inc.1998). Especially, chapters 1,2, 3.

53. Emilie Griffin, *The Reflective Executive: A Spirituality of Business and Enterprise* (Crossroad, 1993); Eric Klein and John B. Izzo, *Awakening*

Recently, Partners for Catholic Health Ministry Leadership has updated a competency model for leadership that was developed by the Catholic Health Association of the United States (CHA) in 1994.[54] This model has a competency cluster entitled "Vocation." It includes the two competencies called "Spiritually Grounded" and "Integrity." Spiritually grounded leaders have the ability to call upon "the spiritual resources of the Catholic faith tradition, their own personal faith and the faith of their co-workers." Integrity consists in acting on one's values and taking risks consistent with those values. These two competencies combine to suggest a spirituality that is geared to put faith into action, to bring spiritual depth to the pressing problems of change.

This interest in spirituality and leadership is particularly important for faith-based health care. The mission statements of faith-based health care are written from explicitly religious perspectives. The inevitable next step question is, How is this ultimate, religious perspective embodied in concrete organizational structures and specific programs? When a mission statement proclaims it is "continuing the healing ministry of Jesus Christ" or it sees people as "the image of God" or it "welcomes all people as a sign of God's universal care," it is articulating the ultimate context of its activities. How does

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Corporate Soul (Fairwinds Press, 1998); David Whyte, *The Heart Aroused: Poetry and the Preservation of the Soul in Corporate America* (New York: Doubleday, 1994); Jack Hawley, *Reawakening the Spirit In Work: The Power of Dharmic Management* (Berret-Koehler Publishers, 1993).

54. "Seeking Leaders for the Future: An Interview with John J. Fontana" *Health Progress*.(May-June, 1999): 50–51. For the original model, see John Larrere and David McClelland, "Leadership for the Catholic Health Ministry," *Health Progress*, (June, 1994): 28–33.

this context make a difference? How does it influence human resources, finance, marketing, ethics, medical practices, and more? This is the ongoing endeavor of mission integration, of bringing all aspects of the organization into alignment with its ultimate vision and deepest purpose.[55]

When spiritual interest arises in patients, medical caregivers, employees, and leadership, it provides a natural and unforced link to the mission statement. Mission statements are always unique appropriations of a faith tradition in the light of its health care mission. However, no matter how diverse mission statements are, cultivating spirit can always be construed as part of their purpose. The underlying rationale is persuasive: "Because we are a faith-based health care organization, we attend to the spiritual interests of patients, the spiritual life of medical caregivers, and the spiritual resources of all employees, especially key leadership." The religious foundation of the organization acknowledges and responds to spiritual interest as one way of carrying out its mission. This becomes a way of bridging the gap between mission statements and practices.

When the spiritual interest in organizational life is characterized as encouraging the deeper level of employees, as focusing on the spiritual abilities of leaders to manage change, and as promoting mission integration, what spiritualities—beliefs, stories, practices—will critique and develop this interest?

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55. On the relationship between the ultimate and particular in the development of health care leadership, see John Shea, "Challenges and Competencies: The Theological and Spiritual Aspects of Catholic Health care Leadership," *Health Progress* (January-February, 2000).

Six: The Spiritual Interest Of Ethics

Every aspect of health care needs to be approached from an ethical point of view. There are ethical reflections and guidelines around medical procedures, patients' rights, business conduct, and a whole array of organizational issues, from hiring to severance. Consequently, there is also a need to think ethically about new initiatives in the area of spirituality. As medical caregivers ask questions about patient spirituality and religiousness and organizations try to encourage the deeper levels of employees and leaders, the usual range of ethical issues will emerge. There will be questions of confidentially, autonomy, truth-telling and deception, privacy, harassment, fraud, minimizing harm, and accreditation. If physicians are convinced that prayer will help the healing process, should they advocate it to their patients? Should medical caregivers pray for patients without telling them? Are spiritual screening tools in general or some spiritual screening tools in particular an invasion of privacy? As changes are introduced, the everyday practice of medicine and organizational procedures will have to be evaluated in terms of their ethical implications.

Ethics is also interested in spirituality because it enters into and shapes decision making and how those decisions will be carried out.[56] Brian O'Toole has described four ways people approach ethics in health care settings. Some people work primarily (1) from principles or (2) in the light of consequences. Other people ground ethical action in (3) the char-

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56. See "Integrating Spiritual Values and Beliefs into Ethical Decisionmaking: Challenges and Strategies for Institutional Ethics Committees," *Ethical Currents* no. 57 (Spring, 1999).

acter of the person acting or (4) in the feelings associated with the action. These diverse approaches are part of the observed way people think and act morally. [57]

However, a spiritual-theological dimension can be present in any of these approaches. The principles can be grounded in theological beliefs; the consequences can be evaluated in terms of religious values; the character that is adhered to can be a spiritual identity that will not be compromised; or the moral feelings may be a tip-off to deeper levels of the heart, levels that have been developed through years of spiritual practice. If a person is religious-spiritual, this dimension most likely will influence their moral decisions. This is especially true in end-of-life care. At that time, religious beliefs about life, death, and afterlife become explicit players in difficult decisions. Ethics is interested in spirituality because it is influential in how people think and act morally.[58]

These concerns of ethics with spirituality are complemented by the interest "everyday ethics" has in spirituality. Everyday ethics does not focus on crunch decisions but on the ability to consistently act on deeper values, especially when the environment does not support those values. It is one thing for an organization to have a series of values—for example, respect for the person, compassion, service to the poor, and excellence. It is quite another thing for the employees of that organization, from corporate leadership to clini-

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57. Brian O'Toole, "Four Ways People Approach Ethics," *Health Progress* (November-December,1998):. 38–43.

58. For an attempt to combine the spiritual process of discernment with the difficult ethical decisions that surround seriously ill newborns, see Michael R. Panicola, "Discernment in the Neonatal Context," *Theological Studies* 60 (1999).

cians, to be able to embody those values in the situations and relationships that constitute their work world. In order to enable a "lived morality," it is necessary to take into account the perceptions, motivations, and sense of identity of the person who is acting. It is here that everyday ethics and spirituality meet.[59]

This is the question of the deeper inwardness that grounds the ethical flow of relationships. In these situations, the question is added to the traditional query, What is the right thing to do? The new question probes, From what space are you doing it? In spiritual teaching, the inwardness of the acting person is crucial to the morality of the action. When actions that are meant to be caring and helpful are performed from conflicted inner spaces, they produce conflicted results. Here is an account of one caregiver's experience of the connection of spiritual inwardness and outer action.

> God bless my mother, and God bless me. We made it through.
>
> She had a stroke and a long period of rehabilitation, and it was clear she was going to have to stay with us for a while. I had all these things in mind: it was a chance to pay her back for all those years. There were these things I was going help her clear up, like the way she was thinking. I wanted to do

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59. Cf. William C. Spohn, "Spirituality and Ethics: Exploring the Connections," *Theological Studies* (March, 1997): 109–123; Donald Evans, *Spirituality and Human Nature* (Albany, N.J.: State University of New York Press, 1993). Especially, chapters VII & VIII; Richard McCormack, *Corrective Vision: Explorations in Moral Theology* (Sheed & Ward, 1994.); Simon Harak, *Virtuous Passions: The Formation of Christian Character* (New York: Paulist, 1993); Dennis J. Billy & Donna Lynn Orsuto, *Spirituality and Morality: Integrating Prayer and Action* (New York; Paulist, 1996); Kevin T. Jackson, "Spirituality as a foundation for freedom and creative imagination in international business ethics," *Journal of Business Ethics*, 9, no. 1, (March, 1999).

the whole job very well, this big opportunity. We should all feel good about it at the end. Little things like that. Some "little!"

Fights? Classics, like only a mother and daughter can have. And my mother is a great fighter, from the Old School of somehow loving it and being very good at it and getting a kind of ecstatic look in your eye when you're really into it. I guess I'm exaggerating. It drives me a little crazy. I hate to argue. Oh, well. . . .

But it got bad. Over a hard-boiled egg we had a bad fight. We'd both gotten worn out, irritable, and frustrated. Boom! I don't remember what about—just about how it was all going and why her stay had gotten difficult and all of us had become more and more irritable and short-tempered.

In the middle of it, she stopped short and said, "Why are you doing all this for me anyway?" It sort of hit me and I started to list all the reasons. They just came out: I was afraid for her; I wanted to get her well; I felt maybe I'd ignored her when I was younger; I needed to show her I was strong; I needed to get her ready for going home alone; old age; and on and on. I was amazed myself. I could have gone on giving reasons all night. Even she was impressed.

"Junk," she said when I was done.

"Junk?" I yelled. Like, boy, she'd made a real mistake with that remark. I could really get her.

"Yes, junk," she said again, but a little more quietly. And that little-more-quietly tone got me. And she went on: "You don't have to have all those reasons. We love each other. That's enough."

I felt like a child again. Having your parents show you something that's true, but you don't feel put down—you feel

better, because it is true, and you know it, even though you are a child. I said, "You're right. You're really right. I'm sorry." She said, "Don't be sorry. Junk is fine. It's what you don't need anymore. I love you."

It was a wonderful moment, and the fight stopped, which my mother accepted a little reluctantly. No, I'm joking—she was very pleased. She saw how it all was. Everything after that was just, well, easier—less pressure, less trying, less pushing, happening more by itself. And the visit ended up fine. We just spent time together, and then she went back to her house.[60]

If the intent of everyday moral actions is to change situations for the better, then the inner space of the acting person is relevant. Ethics and spirituality are partners in the development of the whole person who acts.

When the spiritual interest of ethics is characterized as a concern for the ethical problems, as a concern for the spiritual basis of ethical decision making, and as a concern for the inner state of the ethically acting person, then what spiritualities—beliefs, stories, practices—will critique and develop this interest?

Conclusion

Within a spiritually interested culture, health care becomes a spiritually interested enterprise. This interest coexists with every other organizational and medical interest. It emerges in different areas and is shaped in different ways.

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60. Ram Dass & Paul Gorman, *How Can I Help?* (New York: Knopf, 1985), pp. 191–192.

* Patients, families, and friends are interested spiritually because it promises to provide a way to relate to losses and limits and to respond to the spiritual invitations of reconciliation, gratitude, and love that often arise within these limits and losses.
* Medical caregivers are spiritually interested in patients because it is a way to respect the whole person and to access a potential resource for physical and mental health.
* Medical caregivers are spiritually interested in themselves because it can help renew their vocational commitment and open them to enriching relationships with patients and staff.
* Chaplains are spiritually interested because it enhances their psychological and theological orientation and deepens their emphasis on self-knowledge. It also focuses their work not only on crisis moments but on overall spiritual well-being, not only on individual care but on partnership with local religious bodies, and not only on their own tradition but on the burgeoning interfaith world of patients and employees.
* The organizational life of health care is spiritually interested because it realizes that the deeper levels of employees should be recognized and included, that leaders need to be spiritually grounded to be effective in changing times, and that spiritual concern for patients and employees is a core way faith-based organizations carry out their mission.
* Ethics is spiritually interested because attempts to integrate the spiritual into various aspects of health care will precipitate ethical problems; because spiritual be-

liefs, stories, and practices enter into moral decision making; and because spiritual inwardness is an ingredient in the struggle to implement values into the everyday struggle of delivering health care.

These diverse spiritual interests constitute an openness to deeper spiritual reflection, reflection that will yield a working knowledge of the spiritual (Part Two). They also indicate a readiness to explore appropriate spiritualities, spiritualities that will allow people to pursue these interests (Part Three).