Hostility to Hospitality: Spirituality and Professional Socialization within Medicine. Balboni MJ, Balboni TA. Oxford, 2019

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This book argues for the integration of religion and spirituality into the delivery of health care. It is the product of a fruitful collaboration between Tracy Balboni, a radiation oncologist and palliative care specialist, and Michael Balboni, a congregational minister and sociologist. Their collaboration is strengthened by the support of the Harvard Medical community and the Longwood Christian Community. The latter is a post-modern monastery of healthcare students living, studying, and praying together across the street from the Harvard Medical School. The book has also been funded by a grant from the John Templeton Foundation, so it has a good pedigree. It is a great book and worth engaging with, especially engaging on those parts with which I disagree! For it is only through disagreement and dialogue that we gain further enlightenment on this important topic.

The title is taken from a quote by Henri Nouwen, moving people from *hostis* to *hospes*, but the reference is not clear enough to be able to find the context of the quote. It is an unfortunate title, and we will need to unpack the concept of hostility below.

Content

The book looks at the rise of modern hospital care. It explores the sociological factors informing that care and seeks to provide a place for a contribution of religion and spirituality to that care. The Balbonis identify four big forces informing American hospital care: the scientific and technological dimension, the market and business dimension, the legal and bureaucratic dimension, and the hospitality and compassion dimension. They then argue that a return to religion/spirituality will strengthen the hospitality/care dimension of American hospital health delivery.

The book asks three key questions:

1. Why is spiritual care infrequently provided by clinicians to patients with serious illness?
2. Is, and if so, how is spirituality connected to medicine's basic social structures?
3. Is partnership between medicine and spirituality/religion possible given our secular and pluralistic milieu?

The first question is initially addressed by a survey of cancer patients at four hospitals associated with Harvard and Boston universities. These surveys show that patients are spiritual and they would like to address spiritual issues, but that they do not often have these needs addressed by their medical professionals. The Balbonis list three reasons why spiritual care is so infrequently provided by medical clinicians. Each reason is highly contestable. The first is that hospitals have evolved from institutions

of care to institutions of recovery and cure, with the corollary that hospitals are institutions of science and technology committed to curing people. The second reason is that physicians see themselves as scientists, and that science and religion are in conflict. The third reason is that, with the camouflaging of death, the need for religion disappears. This section closes with a discussion of the loss of religion/spirituality due to the sacred-secular divide, the separation of body from the soul, and the divide between public facts and private values. Taking their cue from Charles Taylor's magisterial *A Secular Age*[1], they decry medicine's immanent frame in contrast to religion's transcendent frame.

The second section of the book addresses the relation between spirituality and medicine's basic social structures. The Balbonis start by defining religion and spirituality. They define spirituality somewhat controversially as a life centred in the person(s) and or objects(s) of one's chief love—however individually understood and pursued. They define religion as the individual and social structures that flow from and facilitate that chief love, including beliefs, practices, relationships, and organizations. They criticise those (like me!) who separate spirituality from religion. They also criticise the secular world which, according to their accounts, has no place for the transcendent and theological reasoning. But they argue that medicine needs theology. Historically, hospitals have arisen on the basis of a theology of care for the sick as a noble calling from God. Belief in a rational God led to the belief in a rational world which allowed for the development of a science for rational medical care.

They then develop a theology of medicine, a theology they say is based on the three Abrahamic faiths: Judaism, Christianity, and Islam, for they are monotheistic. Ironically, they start their theology from the Hippocratic oath, a polytheistic document. They move on to the writings of Judaism and Ben Sira, where physicians are respected, for God has called them to this task. They then look at Jesus and the example of agape love in the Gospels, emphasising compassion for the sick, and move on to how this was developed in the early church through the amalgamation of Hippocratic medicine and Christian compassion in the practice of Basil of Caesarea (d. 379). The Balbonis identify Islam's commitment to the dignity and unity among humans and the particular merit of providing alms for those less well off, including the sick. The physician in Islam is one of the wise ones, respected in Islamic society. Summarising their theology of medicine, they argue that God alone heals, and humans are called to be compassionate to all humans suffering illnesses. A religious vision for medicine recognises the unity of body and soul, provides hospitality for the sick in the presence of the divine, and recognises that medicines are a gift from God.

The Balbonis then develop a theology of the patient-clinician relationships challenging the "scientific" object-observer metaphor in favour of a more relational model. They argue that there is a sacramental nature to medicine, pointing to the transcendent nature of life.

In addressing the third question, they explore the partnership of religion/spirituality to medicine, given the secular and pluralistic framework in which medicine is practised. They do this by resisting immanence and arguing for a greater transcendent world view to medicine. They address some problematic rapprochement strategies, in particular, rejecting "spiritual generalists" in favour of a religious particularist approach. They finish by appealing to end hostility to religion and arguing for the introduction of religion as a basis for developing a hospitable and caring form of medicine in the modern delivery of health care.

Critique

There is a lot to agree with in this book. I support their overall thesis of seeking to reintroduce spirituality and religion into the delivery of clinical care, but at many points, I find that I disagree with their approach and reasoning. I am with them in

resisting reductionism with its temptation to dehumanise care by a fragmentary mechanistic approach to a person's sickness. This occurs especially with sub-specialisation which can obstruct a holistic approach to sickness and health. I agree with them that, as Christian clinicians, we need to learn how to cross the spirituality gap between the patient's spiritual and religious beliefs on the one hand and the lack of spiritual care tools the secular clinician has on the other. I also agree with the need to develop a theology of medicine and a theology of health care. However, I find myself to be like Owen Barfield to CS Lewis, a friend who disagrees with almost everything his friend sees and argues![2]

It is disappointing that the complex practice of hospital medicine has been reduced by these authors to a unidimensional technological science driven by business and administrative dimensions. Clinical medicine is a practical discipline based on science, but it is also a humanity and an art. We clinicians were taught by role models who embodied the highest values of humanity in the delivery of care to the patients. They embodied the virtues of care and concern that we sought to emulate. These mentors, whether Christian or secular, took seriously their role as 'doctors' (the word means 'teachers') who taught their patients what their disease was, and how patients would manage that disease with the help of their medical carers. They created a team with care of nursing and therapy staff committed to the best outcome possible for the patient. The biopsychosocial model is more than simply a recognition that the bio, the 'psycho' (the Greek word for 'soul'), and the social are important dimensions in the care of patients, but the model argues that humans have multiple layers of complexity and that each of these layers interact with each other.[3] Good clinical practice has always recognised the need to address all aspects of the patient's life in order to manage the clinical problem holistically. This included the human dimension, irrespective of whether the doctor believed a person had or did not have (or was or was not) a soul.

There is a reduction in interest in the religious/spiritual dimension of clinical care in modern medicine, as the authors' data shows, but I am not sure it can be blamed on a drive for cure rather than a drive for care. Clinical medicine has always been about "cure seldom, relieve often, and comfort always," and that commitment remains in spite of the loss of religious input. We need to look elsewhere to find the reason for the loss of religious input. It may go right back to the people of God forgetting Moses' injunction in Deuteronomy 8:6-18. I have discussed the loss of religion with my secular colleagues. They agree with me that this is much more a drift of religion/spirituality into irrelevance than a hostile reaction to it, and that in spite of the loss of religion, there is still considerable humanistic care in their practice.

Do physicians see themselves as scientists and, therefore, in conflict with religion? Both aspects of that statement are contestable. While there is a science to the art of clinical medicine, there is still the art of actual practice which cannot be reduced to science. Most physicians, I suspect, have not read anything about the philosophy of science, nor is there a well thought out philosophy of the science of clinical practice. Most clinicians simply practice without developing a formal statement of the science and art of what they are doing. Secular hospitals usually have a formal mission, vision, and values statement expressing the ethos of what they are about, and all have a mandatory ethics committee to ensure that research on patients conforms to ethical norms. So modern secular physicians do not see themselves as scientists, nor do they see themselves as in conflict with religion;[4] they simply do not see the relevance of religious commitments to their ethical clinical care. There may be some hostility to religion in some quarters, but the bulk of secular medicine regards religion as optional for those who are into that sort of thing, but largely irrelevant to the bulk of the care we deliver. I take the main thesis of the book, namely the spirituality gap between therapist and patient, but I find their explanation for

the spirituality gap as due to a scientific hostility to religion unconvincing.

The humane care of the patient has figured prominently in my clinical experience both in secular and Christian institutions, and there are regular articles on this human dimension of clinical care in reputable medical journals. When I was a registrar in the 1970s, Elizabeth Kubler-Ross's *On Death and Dying*[5] was widely discussed. I recall her comment that when chaplains were called on to care for the dying, high churchmen would hide behind the sacraments and low churchmen would hide behind the Bible. Neither had the skills to engage with the person as a person. Ross represents a secular humanistic approach to dying patients that should be highly commended, even though it contains no theology and does not discuss humans as souls.

The authors blur the distinction some writers make between spirituality and religion. The Balbonis simply see religion as the outward working of spirituality. I have some difficulty in the way they define spiritualty as 'chief love', and then in the way they uncritically accept religion as something good worth commending. I often encounter patients who say they are spiritual but not religious, and there are plenty of other thinkers in this area who are trying to include spirituality without formal religion.

Why not formal religion? Religion, particularly now that institutional sexual abuse has been exposed, is rejected for good reasons. Such a rejection is not new. The Carpenter of Nazareth for confronting the religion of the day, and his followers, suffered considerable religious persecution. This is not a rejection of religion, but a simple pointed comment that religion is not always beneficial. Even in clinical practice, we encounter patients who have been damaged by formal religion, and proper spiritual care requires the clinician to help the damaged patient find healing in that area.

And what of the concept of spirituality? The basic word 'spirit' is related to breath and liveliness. Thus, an inspired person has lots of life, and a spirited person or animal is very lively. Conversely, a dispirited person has lost their liveliness, and a person who has expired has lost their breath and is dead. The Holy Spirit breathes life into the dead and gives life for the future. In my area of clinical practice, addiction medicine, we often quote Carl Jung's famous dictum "*spritus contra spiritum*" (the divine spirit driving out the spirit of alcohol) as a further exploration of the place of spirituality in addiction care. Spirituality is not just about care for the dying, but a wholistic exploration of meaning and purpose for those struggling with existential questions. There are other dimensions to spirituality that need exploration. Harvard psychiatrist George Vaillant, in his *Spiritual Evolution*[6], argued that spirituality was found in the emotions in the limbic system, rather than a rational, lexical activity. In the end, I was able to persuade Dr. Vaillant that the lexical and the limbic go together[7] and that spirituality is not just about love but also about truth, justice, mercy, and equity. The Kingdom of God is the upside-down Kingdom which seeks justice for the marginalised and the oppressed. It is not just about individuals but also about humans in society. The implications of this will be explored below.

The last two paragraphs might fall into the trap of regarding spirituality as good, whereas religion is bad. I do not think that. Some spiritualities are bad, and some religions are good. A patient's spirituality/religion needs more careful evaluation than either being ignored or simply affirmed.

Is there really hostility in secular society towards religion/spirituality? Once we have a more nuanced view of spirituality and religion, we can see where some of the hostility might arise. Those who have suffered abuse from priests and other religious people, or who know those who have suffered such an abuse, would well feel justified to be hostile. Women, especially, have reason to feel that a hierarchical patriarchal religion deserves to be treated in a hostile fashion. However, for the bulk of my colleagues (and indeed even my Christian colleagues) religious commitments are not directly relevant to clinical care.

Is hostility the best description of the current situation in hospital medicine? It may be so in Boston, where not so long ago Puritans abused Quakers. Modern secular society quite rightly condemns the hanging of Mary Dyer and other Boston martyrs. Those were the days of magisterial Christianity—Christianity enforced and defended by state laws— and most Christians these days prefer to see their faith stand on its own two feet rather than be enforced by the state. The US view of the separation of church and state has some justification, but in spite of this, for the most part, there is simply a secular indifference. To label that as hostility creates unnecessary barriers between Christians and the secular world. A more thoughtful approach might well create better bridges. I have some explaining to do if I were to lend this book to my secular colleagues.

The immanent/transcendent anthropology can also be contested. I looked in vain in the book's rather scarce index to find any discussion on psychology, psychospirituality, and neurophilosophy. I agree with the writers' contention that a diminished anthropology can affect clinical practice. Thus, in the field of psychiatry if one reduces human distress to depression and sees that as a chemical imbalance of the brain, clinical care will be rather limited. Humans are more than a set of chemical receptors, and human distress has personal, social, and relational dimensions. It also has a spiritual dimension. We do not need to invoke an immaterial soul to deal with this problem well.

There is a vast literature on what the Balbonis call the transcendent dimension of humans which does not invoke theology or a dualist anthropology. Consciousness, qualia, emotions, perceptions, the sub-conscious, the exercise of reason, and the exercise of the will all spring to mind. Each of these dimensions could be bundled up into what the Balbonis call the soul, but this is unnecessary, and even Christian neuro-philosophers suggest that the traditional understanding of the soul needs a major rethink.[8,9,10]

The modernist fact/value distinction is also challenged by the post-modern understanding that all facts are theory laden and that no commitment is objective and value-free. This is good news for Christians for it acknowledges that there is no value-free secular space. Thus, Christians can come to the secular marketplace with their commitments and expect to be respected for those commitments. This describes a secular space more in keeping with an Indian society which respects and allows space for all religious commitments, Hindu, Muslim, Christian, Jain, etc., respecting the different commitments and common values, or as Karl Barth put it, the proclamation of Christ is neither "hidden nor diluted."[11]

Why try to define spirituality and religion? Some complex activities, like baseball (or its slower cousin, cricket) are better described than defined. Spirituality is like that—the attempt to define it as one's first love trivialises the rich complexity of the term and centres it too much on the individual. I commend the spirituality of the Kingdom of God as a richer alternative, and I will explore its implications below.

It is a pity that spirituality here has only been applied to the oncological population. If spirituality, as outlined above, is about liveliness, hope, meaning, justice, and truth, then spirituality should be more than just ideas applied to the end of life. I, personally, have found this to be a rich vein in dealing with addictions and mental health.

I find the Balbonis' theology of medicine somewhat limited. Their theology centres on three theses:

1. the human body and soul must be treated together,
2. that hospitality is the foundational motive driving clinicians and hospitals, and
3. that medicine is a divine gift.

This is disappointing, for if theology (which after all was the queen of the sciences) is the science of God, then God is the subject of theology, and we need to centre it far more on God than on what we

are doing. When we do, we find that one of the central themes of Scripture is that God heals. In fact, salvation and healing are closely linked. A theology of medicine has to ask questions about the relation between sin and sickness, salvation and healing. This may be difficult in the area of care for the dying, and we, as Christians, need to challenge the hubris of doctors playing God, but we are still agents of hope and healing of life and purpose. We then come to the fraught issue of divine action in a mechanistic universe and how we, as spirit/flesh amphibians, stand in the interface between the seen world of the everyday and the unseen world of the Kingdom of God. We also need to develop a theology of suffering and address the question of the existence of God despite suffering.

I have found myself encountering non-medical thinkers trying to develop a modernist Grand Unified Theory of Everything, in this case limited to a grand unified theory of medicine, whereas we post-modernists are far more circumspect in what we think we can achieve with our patients; we know fragments only. I recently asked a very respected consultant physician interested in the history of medicine what his philosophy of medicine was. His reply, "To be humble and to learn from your mistakes." Hardly a grand unified theory but more suitable to the wisdom of the book of Proverbs than a learned dissertation!

I have difficulty with defining spirituality as "first love." This leads to a find a niche of spirituality in extending the hospitality and care dimension into modern clinical practice and centring spiritual care on the individual only. But what if spirituality centred on the Kingdom of God, the rule of God over every aspect of life and that that rule was characterised by righteousness, justice, mercy, truth, compassion, and equity? What if this spirituality sought to develop a body of Christ here on earth committed to the rule of God in every aspect of life, including the scientific and technological, the business and market dimension, the legal and bureaucratic dimension, as well as the hospitality and compassion dimension? There is a spirituality of health delivery and the need to challenge the unjust structures, especially in the United States, where families can be only one sickness away from bankruptcy and destitution.[12] Christians in the US need to challenge the fear of socialism and the worship of the dollar in order to provide for the poor and the marginalised, just as God expects. Bureaucratic management of healthcare is not unspiritual, it is deeply affected by justice and truth. Science is about truth, and technology is about justly implementing that truth. This will require confronting unjust and devious practices like deceit in research and drug companies' temptation to suppress adverse outcomes or false advertising. There is so much more to spirituality of health than the laudable wish by the Balbonis to enhance the clinical encounter with an exploration of spirituality with the dying patient. What if we humanised medical care according to the attitudes of the one true human, Jesus Christ, and sought to bring about His hidden kingdom of salt and light?

Conclusion

Having laid out my reservations, may I applaud the Balbonis for their work and research? They are to be commended for entering such a fraught area and raising such an important issue. I will be one with them in developing the spiritual dimension of clinical care in the secular world, and if I ever travel to Boston, it would be good to spend some time in their community for mutual benefit and encouragement (Romans 1:11).

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