Faith in Health & Healing

Integrating the church with health services

Setting the scene for the Birmingham conference
24/25 April 2013

Contents

Disclaimer

The process of putting these insights together in a single document has inevitably involved a good deal of filtering in order to offer a coherent and integrated account. The responsibility for this lies with me, and inevitably therefore is flavoured with my own perspective. This process of interpretation and writing may well have adapted insights that participants offered to the process. Inevitably, with a wide variety of participants, there will be varied views, and I would not expect all of them to agree with every point made in the text. No attribution is made to specific participants, except where existing published work is referenced.

This report was compiled by Paul Holley
February 2013, Geneva

Introduction

This publication draws from two years of deliberation by participants in the planning and designing of a conference to consider the health mission and healing ministries of churches. It introduces the 3 key themes determined in that process, and explores many of the issues that have emerged in discussion. This paper does not pretend to have explored all angles or brought together all published insights into these themes. Rather, it pulls together a rich tapestry of experience and learning shared by the participants.

The conference will draw together those who are actively engaged with projects that express the healing vocation of Christian faith. It will make this activity more visible and challenge Society to look afresh at the many roles churches play in supporting the health of the people. In this way, the conference planning group believes that the ministries of churches can be integrated into evolving patterns in health services.

Whilst much of the material is UK-focused, the past two years of deliberation has also benefitted from insights into health mission in other parts of Europe, the United States, various African nations and beyond. With the UK's unique approach to healthcare, tied as it is to state-led secular policy frameworks, it has been important to see the healing ministries of churches through a wider lens. The ubiquity of church owned health programmes and hospitals suggests that new thinking could emerge within the UK, consistent with international models and practice.

Revd Paul Holley MPA
Coordinator, Anglican Health Network
Conference Director

www.anglicanhealth.org/ConferenceHome.aspx

Background

The initiative for this conference emerged from conversations at a day conference in Burrswood Hospital, Kent in July 2010. Amidst the various presentations, it seemed that there was a common trend: Christian healing initiatives and primary care medicine were drawing more closely to one another. Paul Holley, Coordinator of the Anglican Health Network convened a meeting between Bishop John Pritchard, president of the Guild of Health, Russ Parker of Acorn Christian Healing Foundation and Gareth Tuckwell of Burrswood Hospital. It was agreed that a conference should be organised to draw in the variety of health and healing activities offered by churches and Christian agencies so that trends could be examined in more depth.

A process of consultation followed, during which the range of partners came together to form the planning group. The Guild of Health offered a grant to support the organisation of the conference by the Anglican Health Network. Parish Nursing Ministries UK agreed to provide some administrative support.

In February 2012 Paul Holley convened a panel of experts to act as a reference group. These were drawn from a range of academics and practitioners to consider the theological, clinical and political issues surrounding the role of churches in health care. This included input from 2 representatives from the Church of Norway who were able to share learning and experience from church hospitals and congregational health initiatives. This meeting provided thinking that helped flesh out the 3 key themes identified by the planning group. The conference programme took shape in response.

The conference venue was chosen to allow for maximum access for those from throughout the United Kingdom and Ireland. Close to Birmingham International Airport, it also offers good access from other parts of the world.

The workshop programme is developing in response to the growing range of groups and individuals who are now involved with the conference. The event itself will be the culmination of a process in which a wide variety of stakeholders will have pooled their experience and learning, and be ready to look together at future possibilities.

Planning group

The following have been members of the conference planning group:

Convener: Revd Paul Holley
Anglican Health Network

Revd Stanley Baxter
Guild of Health

Dr. Gareth Tuckwell
Burrswood Christian Hospital

Revd Christine Garrard
Burrswood Christian Hospital

Revd Dr. Russ Parker
Acorn Christian Healing Foundation

Revd Chris Mackenna
St. Marylebone Healing & Counselling Centre

Parish Nursing Ministries UK

Jennie Fytche
Parish Nursing Ministries UK

Revd Dr. Helen Wordsworth
Parish Nursing Ministries UK

Geoff Waghorn
Parish Nursing Ministries UK

Claire Goodman
Parish Nursing Ministries UK

Premier Mind & Soul
EXPLORING CHRISTIANITY AND MENTAL HEALTH

Revd Jonathan Clark
Premier Mind and Soul

Elizabeth Baxter
Holy Rood House

Revd Dr. David Evans
USPG

Dr. John Geater
PRIME

Professor Helen Leathard

Dr. Peter Rookes

Dr. Sandy Bradbrook

The Guild of Health has provided grant support to the Anglican Health Network for its leadership in developing and delivering the conference.

Reference group

In order to look in more detail at the key ideas and themes for the conference, the planning group commissioned a reference group.

The following participants took part in a meeting at the Anglican Communion Office in London on the 3rd February 2012 to examine the three themes of the conference:

Dr. Luke Bretherton
Reader in Theology and Politics at Kings College, now Associate Professor of Theological Ethics and Senior Fellow, Kenan Institute for Ethics, Duke University.

Hannah Clifton
Chair, ME Trust

Revd Professor Christopher C H Cook
Director of the Project for Spirituality, Theology and Health at Durham University

Professor Grace Davie
Emeritus Professor of Sociology at Exeter University

Dr. Jamie Harrison
GP, Deputy Director of Postgraduate School of Primary Care for the Northern Deanery, William Leech Fellow in Applied Christian Theology, St John's College, Durham University

Revd Professor Kjell Nordstokke
Professor of Theology, Diakonhjemmet University College, Oslo

Revd Canon Dr. Andrew Todd
Director of Chaplaincy Studies, St. Michael's, LLandaff

Revd Johan Arnt Wenaas
Church of Norway

Dr. Paul Worthley
Senior Physician, Burrswood Christian Hospital

The meeting was chaired by Revd Paul Holley

Why should churches get involved in health care?

Health is often popularly understood as the treatment of sickness and 'dis-ease'. However, upon its founding in 1948, the World Health Organization (WHO) recognized that such an understanding has its limitations, 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. In the late 1940s the practice of medicine was beginning to yield significant gains. It was a period in which psychological therapies were gaining widespread acceptance and in which post-war nation states were rebuilding not only their physical infrastructure, but also implementing

'Faith is becoming more valued in the pursuit of health'

their role as comprehensive guardians of people's welfare. The implication was that newly developed scientific and political mechanisms could deliver a higher standard of health and wellbeing to all citizens.

Until this point churches had largely taken responsibility for the care of the sick. This had been their chosen vocation since the founding stories of Christ's healing of the sick in the gospels.

Despite a growing understanding of sickness, the medical profession only really began to intervene successfully in curing common diseases from the late nineteenth century onwards. Whilst the churches had until that point offered a healing environment for the capacities of mind and body to find their own resolution to sickness, science offered successful treatments to influence and enhance the body's intrinsic healing capacities. In time, the compassionate care that Christian institutions offered was overtaken by the effective innovations of medical science. As governments aspired to offer such advances to their entire populations, they began to involve themselves in constructing health systems. In the case of the United Kingdom, the state went as far as to take over all the historic healing institutions of churches to create a nationalised health service.

Much as medical science has made critical advances in curing disease, the denuding of compassionate, spiritual care in favour of an increasingly secularised scientific interventionism has been detrimental to the notion of holistic wellbeing. Carried perhaps by enlightenment assumptions about the demise of religion, societies have tended away from religious environments as places of healing. In effect, the self has been broken down by medical determinism into its constituent parts of body, mind and spirit. Targeted interventions are designed to impact these constituent parts as if they are isolated autonomous systems. As a result, faith is now undervalued in the processes of fixing body parts and psychological patterns.

Churches retained their presence in health services through chaplaincy roles. But the nature of this ministry has changed substantially in recent years. It now focuses less on religious care and more on the neutral notion of spiritual care. Economic pressures and the demand for evidence based effectiveness makes chaplaincy more vulnerable to decline. Churches will now have to exercise considerable initiative to increase their impact on hospitals and health organisations.

Against this uncertain background, it is the experience of each member of the conference planning group that faith is in fact becoming more valued in the pursuit of health. This is expressed in a wide variety of contexts. For example, in many parts of the world, church hospitals are regaining their confidence as Christian institutions. They are learning to integrate the best techniques of compassionate care and scientific interventionism in order to provide class leading health outcomes. In community health, congregations are offering their support to patients in primary care. They offer

listening services to allow people to untangle the many factors that constrain their sense of wellbeing. Church buildings increasingly offer spaces where healthy lifestyles are promoted and supported. Christian people can be found on the streets of city centres looking after those whose partying has caused injury or vulnerability. Retreat and healing centres take time with those whose experiences have decimated their humanity. The growth of healing prayers in churches is also indicative of the interactive role between faith and health.

The nature of health and disease has also changed significantly. Whereas the fundamental building blocks of health services were constructed to combat infectious diseases, they are now having to adapt to the lifestyle-related diseases such as cancers, heart disease and diabetes. These chronic conditions require long-term support at primary care level, and thus may benefit from communal and religious structures that provide care and practical help. Perhaps the most challenging health priority is to prevent rather than treat chronic diseases. Obesity and poor mental health are two of the overwhelming threats to health in contemporary society. Churches may be able to take a significant role with other community organisations in empowering people to make changes to lifestyles, both as individuals and as neighbours, thus mitigating this tide of poor health.

Successive governments have sought to reform the National Health Service in order to provide a mixed economy of providers and to strengthen the role of primary care. Whilst this is a contested and controversial development, it nevertheless offers opportunities for churches to engage with health services in new ways. Heath organisations such as Primary Care Trusts have already commissioned projects with churches. The new Clinical Commissioning Groups may find the confidence to resource innovative systems of community based care for chronic conditions. Health and Wellbeing Boards may find routes to achieve their goals through the galvanising of local communities.

The conference is designed to provide a 'rich picture' of the many and various health related activities of churches and Christian agencies. In considering current trends, the conference planning group believes that church leaders and policy makers will want to give fresh attention to this part of their common task. Herein may lie opportunities for both Church and Society to renew a partnership to more effectively achieve 'complete physical, mental and social well-being'.

Health, dying and human flourishing

What constitutes a healthy human person? There is no absolute answer to this. Each person's sense of wellbeing is determined by many factors within themselves, in their family circumstances and in their social and physical environments. Each person has their unique point of balance with these factors, and each individual can tolerate difficulties or even extremes in some factors and yet remain healthy and happy. Each person is different, and the points at which different factors, or combinations of factors, cause people to cease to flourish in their lives varies between individuals and within individuals in different phases of their lives.

'Our length of life and capacity to overcome disease has created vastly more optimistic aspirations for wellbeing'

People will measure their health and wellbeing in comparison with others and according to their own subjective judgements. They do so because there is no context in which all forms of poor health can be banished. A person is likely to set her own parameters for what she considers to be healthy. Disabled people have demonstrated that humanity is so diverse that absolute measurements of health prejudice the potential for people with different characteristics to realise their contextual wellbeing.

Discussions of wellbeing have been a feature of philosophy for millennia. These take account of sickness and lifestyle, but are often more focused on determinations of existential meaning. However, the context in which wellbeing is now considered has been transformed by medical science. With life expectancy having risen above 80 in the United Kingdom, the length of life and its capacity to overcome disease has created vastly more optimistic aspirations for wellbeing. More emphasis is now given to body health in the calculation of wellbeing than was possible in the past, even though this picture is clouded by the longer periods in which the elderly now experience chronic illness.

Further, the notion of wellbeing has begun to emerge in a wide variety of discourses; in public policy, theology and economics:

1. Social determinants of health such as poverty, nutrition, education, employment and environmental conditions are highlighted so that health impacts can be incorporated into all arenas of public policy.

2. A 'happiness' discourse is leading politicians to form new judgements about the purpose and design of economics in reaction to the reductionism inherent in measurements of Gross Domestic Product.

3. The Christian tradition pre-supposes that spiritual notions of salvation and healing also inform the overall wellbeing of the person. The healing movement has carried this tradition in recent times.

These factors are expanding popular notions of health and wellbeing. They seek improvements from a wide variety of sources.

However, there is a large and darkening cloud hanging over the health of the people. In general, they have yet to fully appreciate the impact of lifestyle patterns on their health and wellbeing. The impacts of obesity and the roots of depression/anxiety are the products of unhealthy patterns of diet, exercise, relationships and activities (professional, leisure etc). Science is gaining better insight into the biochemical processes affected by these patterns, especially in relation to the interaction between genes and shifting body chemistry, but there remains much that is indeterminably complex about the human self. Thus there are mixed messages and grey areas about lifestyle-related impacts on the self, and people struggle to feel sufficiently empowered to make changes.

Christian theology identifies the 'individual within community' as the key category in which to address the human person. This implies that the health of the individual is dependent on the health of the community and vice verse. Those who wish to improve the health of the person, should at the same time consider the patterns of life within the community in which he lives.

In this context, how can human flourishing most effectively emerge? Herein lies a significant tension in public policy. The notion of subsidiarity suggests that wellbeing emerges most strongly in the context of people's most intimate relationships. This is the basis for welfare systems in Southern Europe. Northern Europe, and particularly Scandinavia, has operated a more technocratic approach to welfare on the basis that it is the responsibility of the body politic to care for each citizen. The space for religion is likely to be stronger in Southern rather than Northern European systems, and indeed the secular character of welfare varies accordingly.

The relative merits of relational care are thus contested. Should families, supported by communities, bear the burdens of care? Or should the professionalised state or state-mandated institutions take that burden on behalf of the whole of society? Beyond the financial implications of state-sponsored care, a key challenge to this model is whether the technocratic project to manage care has the capacity to sustain human relations. If familial and communal structures are key for person-centred wellbeing, then individualised professional care may always be found wanting. Having said that, the capacities of families and communities fail often to care adequately, or reach some who may quietly fall through the net.

Ideally, a healthy human person will find herself empowered by family, social circumstances and religious experience to flourish within her own capacities. Medical interventions will have a role in positively influencing biomedical elements of her body. Welfare services will support the best that family and community can offer to her care. How these various elements can be weaved together by church, market and state remains the key challenge.

Theologies of medicine and health

Has medicine replaced religion as the primary source of hope and salvation for the people? The Gospel stories of Jesus' healing ministry suggest that most people were drawn by his miraculous powers. Reading the Gospel accounts, it is tempting to think that once they were cured, people were happy to go their way without further interest in his purpose. There were of course greater subtleties to Jesus' mission, but at the very least these stories corroborate the impression that what people want above all is relief from their suffering. Jesus was remembered as providing this relief.

Whatever the realities of Jesus' healing ministry, the Christian tradition was left to grapple with the realities of sickness and suffering without the benefit of miraculous cures. The growing Christian discourse of theodicy taught people how they might live with their pain. Rudimentary medicinal techniques were practised where possible, but care and compassion were the main therapeutic responses of the Church. This continued until the relatively recent past.

'The pursuit of health has shifted to the domain of lifestyle.'

Modern medicine emerged in the late 19th Century to offer cures that few had experienced through their religion. Tackling the ravages of transmissible diseases, the

medical profession began to relieve people of their suffering and pain. People were no longer powerless in the face of 'consumption' or 'the pox'. This was a proactive approach to theodicy; to overcome and defeat suffering. It reflected the memory of the miracle-working Christ.

In the process, the relationship between doctor and patient began to bear similarity to priest and people. Indeed, with the emerging discipline of psychology, doctors were increasingly confronting the fears and anxieties of their patients. They developed techniques to seek resolution of deep-seated problems. The intimacies uttered in the consultancy room largely replaced the intimacies shared in the confessional or pastoral visit.

In contemporary society, it might be assumed that cures are expected of medicine whilst only forbearance remains the preserve of religion. On this basis, the promises of medicine are bound to be more successful in drawing people's interest.

However, the application of medicine and the pursuit of health should not be conflated. Before modern medicine made an impact, public health interventions made the largest difference to the health of the people. The construction of sewerage systems and the improvement of housing stock and places of work significantly improved life expectancy and quality. Churches and Christian philanthropists substantially aided this pursuit of health. Enterprises such as these had a religious significance to it. The guiding principle to love one's neighbour led Christian leaders to seek improvements to the health and wellbeing of the people. Whilst medicine often accompanied this work, it was not the dominant factor. Such an approach could be conceived as a 'Salvation Theology': The promotion of greater health and wellbeing for the people was a reflection of the coming Kingdom in which people would rise towards their intended perfection in God's creation.

Medicine may be conceived as a positivist theodicy to overcome suffering, but it has not lived up to expectations. The commitment to saving treatments may not be the optimistic narrative that it once was. The pursuit of health has once again shifted to the domain of lifestyle. Public health, always the poor relation to clinical medicine, emphasises prevention rather than cure. It is perhaps in this 'salvation project' that the churches can once again offer a significant contribution to improving the health of the people. The challenge is less technological than in the late 19th Century. It involves personal and communal behaviours. This is hard territory for public authorities to grapple with.

Medicine and people: medicalisation, personhood and religious experience

Does modern medicine dehumanise people? The sociologist Ivan Illich coined the phrase 'medicalisation' in 1974. He observed that the patient tended to become fodder for the medics, with an attendant loss of autonomy, freedom and dignity. In a later lament in 1995 he argued that this process had gone one step further: 'Medicalisation led people to see themselves as two legged bundles of diagnoses. It did not, however, disembody self perception; today, systems thinking does. People now watch the curve of their vital parameters'.

An example of such disembodiment emerged during a lecture from a well-known surgeon. He offered his framework of thinking in the treatment of a woman with cancer. He described her body as like a motorbike that she needed to dismount until he repaired it. Mind and spirit needed to be disconnected while the body was 'fixed'. It is possible the surgeon did not expect the nature of cancer to affect these other constituent parts of the whole person. Or perhaps he thought it unnecessary for him to deal with the person as a whole, and that he could ignore the impacts of his intervention on the mind and spirit. Maybe he assumed that another member of the team might address this. However, in passing this perspective on to the woman concerned, he will have influenced her self-perception and limited her capacity to experience care at deeper levels.

Naturally, each person faces emotional and spiritual needs that surface in times of illness and vulnerability. People need opportunities to make sense of and derive meaning from what comes their way. They should not be treated as mere biomechanical machines, even if the principle intervention required is highly technical.

There is a tension in health systems between a desire to provide holistic care and a need for extreme expertise in evidence-based practice. This need for expertise requires many doctors, nurses and other health care professionals to operate within specialties and sub-specialties. They thus provide treatment for only one aspect of a patient, which may be experienced by that person in terms of dehumanisation. Time pressures combined with patients' struggles to articulate complex health concerns can lead to people feeling they have been misunderstood. They do not receive appropriate treatment as a consequence. The management of health system processes may also be responsible for squeezing out the space for relational engagement.

health have been extensively demonstrated. The World Health Organization continues to resist incorporating spirituality into its definition of health.

Despite this, the need for nurses and occupational therapists to assess patients' needs for spiritual care is being increasingly recognized. The debate has moved on to consider the extent to which people qualified in these professions can or should provide spiritual care, and when it is appropriate to involve spiritual care professionals such as hospital chaplains.

This is particularly important in relation to mental health, not least because the incidence of mental health problems among the population at large is very high. Surveys of those who access mental health services tend to report high levels of spiritual interest and activity. However, mental health professionals struggle to engage with the spiritual sphere, indicating a significant disjunction between where the patient is at and what the professional can offer.

'Prayer introduces transcendence and crosses boundaries that are constructed to maintain secular space.'

Relational engagement is one thing; religious care is another. The social construction of modern medicine is based in secularity. However, this notion of secularisation as a neutral safe space is a fallacy that is biased against religious notions of transcendence. Given that this is the setting in which most patients are receiving treatment, it is little wonder that many are suffering the ill effects of the resulting dissonance. Some psychiatrists even respond to religious talk by assuming this is part of the delusion of the patient, which is profoundly harmful. Nevertheless, this secular space is often closely guarded even though the positive links between spirituality and

The language of God and reference to specific religious dogma is problematic in the seeking of appropriate modes of treatment and care. Nevertheless, patients do articulate their faith in classic religious terms. Clinicians generally resist engagement in discussions of faith, perhaps hoping that the patient's clergy will cover the spiritual elements. It is feared that any partiality about spiritual matters shown by the clinician may become harmful.

Can the clinician expect to have sufficient understanding and distance to engage with their patients in matters of religious concern, especially in a multi-religious environment?

One particular physician was reported to utilise spirituality in clinical practice. He offered the serenity prayer with reference to God removed. But what is the nature of such a prayer if it is reduced to mere wishful thinking? The contemporary articulation of 'spirituality' may be an easier phenomenon to engage with than institutional religion for those who practice medicine, but it is far from adequate in the context of transcendent revelation.

The culturalisation of religious practice in health services can be a way of developing responses to people of faith, but it can also lead simply to displacement of the true spiritual needs by reducing them to cultural practices. The language of transcultural approaches to people can be helpful to re-engage clinicians in matters of religious practice, but it still falls prey to them distancing themselves from the real issues of faith. There are mental health trusts that have instituted spiritual care pathways into their systems, but in some cases they fall prey to a tick-box approach to care, and do not necessarily delve deeper.

The action of prayer in a therapeutic relationship remains particularly controversial. The theological tension between transcendence and immanence remains at the heart of the challenge, since it cannot be considered from a scientific perspective. Those who articulate an interest in spirituality in the clinical setting generally resist talk of transcendence. Prayer introduces transcendence and crosses boundaries that are constructed to maintain secular space.

How then might space be created for religious talk and spiritual care in the currently secular environment? The Lutheran notion of diakonal hospitality offers one way to approach this. Church hospitals in Norway provide care without the imperative for religious meaning. This act of service represents an interpretation of neighbourly love that does not depend on conveying overt religious dogma and ritual. All members of staff are trained in 'diakonal values', which are tied in with the gospel imperatives for care and compassion. Designated staff on each ward are mandated to oversee the implementation and animation of these values.

Another model is pioneered by Burrswood Christian Hospital in Kent. Arising from the healing ministry of Dorothy Kerrin, it has more recently evolved its practice to integrate religious and spiritual experience into contracted clinical care services for the NHS. The Christian context is more visible and available, but is sensitively implemented so that none feels pressured to experience care tied in to Christian dogma.

Growing interest in more holistic approaches to care may well be demand-led. A wide range of people question the capacities of medicine for wellbeing. Perhaps they are more relational in other aspects of their lives and demand more holistic approaches to health care. The growth in access to information is likely to be another factor. The internet has allowed people to pursue clinical information themselves. This brings into question the traditional power imbalance in the patient - doctor relationship.

Consumer demand seeks individualised options. Increasing wealth and political influence amongst more affluent members of society create the conditions for change. However, the impacts of consumer autonomy do not necessarily provide much space for the communitarian concept of religion. It may in fact encourage spiritual space that is subjective and self-focused, in contrast with shared religion. In this melting pot of religiosity, it is increasingly difficult to engage with the wide diversity of religious meaning.

If the practice of medicine too often dehumanises and 'medicalises' people, then it is incumbent upon churches to re-assert the true nature of personhood. The experience of health and wellbeing depends upon it.

Dying

The theologian, Jurgen Moltmann, described true health as 'having the strength to live, the strength to suffer and the strength to die'. People looking for the strength to die face the challenge of sustaining or reconnecting with their faith. Many find themselves caught between the religious certainties of a by-gone age and a belief in scientific and technological solutions that are based within a secular discourse. They have values and beliefs, but they do not find it easy to say exactly how they relate to organised religion or other more disconnected spiritualities. Those with a secure belief in God attest that spiritual care recognises and responds to the needs of the human spirit when faced with progressive disease. It involves compassionate relationship and a common narrative of eternal transcendent meaning.

'... the strength to live, the strength to suffer and the strength to die'

How society cares for people who are dying is an indicator of its wider compassionate character. Noting the inadequate care offered in the clinical environment of the hospital or the primary care setting, Dame Cicely Saunders established the first hospices. Behind this initiative lay Christian convictions that greater compassion and care should surround end of life care.

The desire to avoid death is dominant amongst most people. Doctors have developed ever more sophisticated techniques to delay the moment of death in the hope of achieving the longest life possible. In so doing, it has become commonplace for family members to feel

they should authorise all available medical strategies in the face of the impending death of their loved one. Now, Illich says, with the shift to the systematisation of medicine and the patient - 'Agony came to be seen as the effort of a medical team, and death as the team's frustration by an ultimate act of consumer resistance.'

In parallel to this resistance to medical heroism, churches have had a great deal to say about the conscious choices people make in navigating end of life care. In stressing the need to avoid pressure being placed on the vulnerable to choose to die prematurely, churches have campaigned to prohibit assisted suicide or euthanasia.

How, therefore, can people be helped to embrace and experience a peaceful and timely death?

Memories of the art of dying lie within families, but these do not easily emerge in contemporary clinical environments. Ideally, the churches' ministry of healing could be valuable. Having said that, there is a common misunderstanding of the nature of healing; that it is associated with cure. Professionals working in palliative care are generally wary of the word 'healing'. They are rightly fearful of raising their patients' hopes through false optimism; a confusion in the nature of the hope of healing at the end of life. Morris Maddocks' description of Christian healing as 'Jesus Christ meeting you at the point of your need' surely embraces both living and dying, but is rarely seen in that context.

A physician member of the reference group offered the following insight:

The challenge that Moltmann and Illich throw at me in the 10 minutes I have with my patients is to believe, and then embody, a lived out view of the person before me – as an embodied person with whom I am travelling on a journey that involves us both (Illich later on appeals for a revival of the amicus mortis – 'one who tells you the bitter truth and stays with you to the inexorable end'). This journey is one in which my own strength to be fully human is challenged – my capacity to rejoice and suffer with another person, seeking to share together an acceptance of both life's joy and the grief of death.

This means that for the man whom I now see every couple of weeks, I am impelled to ask not so much about his lung cancer treatment but to focus on his embodied self; as a person 'fully alive'; so that together we can share his joy and suffering in a way that transforms both of us, rather than merely act out a transaction between us. Herein lies our vocation in an increasingly technocratic, transactional, and systematised world.

Much needs to be done in order to adapt common thinking to the realities of dying in the context of a highly medicalised culture. Christian experience and thinking has resources to support people in pain and to strengthen them to die. Healing is appropriate in this process, but needs careful mediation. Both professionals and family/friends need to discover afresh the arts of accompaniment in dying. This is an area where further reflection is essential.

The healing ministries of the church amongst individuals and communities

According to Archbishop William Temple, a church without a healing ministry is engaged in only a partial expression of the gospel. Looking back at the ministry of Jesus, it is evident that healing was the most well understood expression of the coming of the Kingdom of God. This is what drew people to Jesus and what opened them to his teaching and his wider message. But Jesus' ministry of healing was more than a 'sweetener' for the spiritual dimensions of salvation. It was an intrinsic experience of the coming Kingdom of God in which the grace and blessing of God was increasingly made apparent.

Healing may thus be considered as an encompassing term alongside the notion of salvation. In fact, in order for complete wholeness to emerge, the Christian tradition affirms the need for the reconciliation of the individual to right relationship with God. This applies not simply to the individual but to the wider community and indeed the physical environment in which humanity exists. The apostle Paul writes that the groaning creation awaits its full redemption and healing. Without attention to this universal notion of salvation, our understanding of healing will be only partial.

However, there is value in drawing parameters around the ministry of health and healing to the individual as he or she is impacted by the various surrounding social and environmental conditions. The action of the local church in the mission of God will engage with the widest possible application of a healing ministry, but will also develop specific activities to support individuals to negotiate their way through the imperfect conditions in which they live. This approach to mission engages the realities of suffering even as eschatological hope is proclaimed and pursued.

The application of a healing ministry within the local church must therefore arise from this broad notion of mission. People recognize their 'dis-ease' as a factor of the world in which they live. Public health concepts inform this picture further as they describe those social determinants that impact people's health. Addressing these relational, social and environmental conditions in which people live go a long way to bringing better health and well-being. Interventions can be made by a church community to improve such conditions. And, at the same time, the church can support the medical, emotional and spiritual factors through which an individual may improve their personal health even if progress in the factors affecting them is limited.

The degree of attention churches can give to their healing ministries can therefore be very extensive, thus meeting William Temple's challenge to express the whole gospel.

Pastoral and liturgical healing ministries

The collective spiritual activities of the Church are key resources for healing. People are cared for, comforted, encouraged and reconciled through the pastoral and prayerful action of the people of God. The sacrament of Holy Communion may offer people a significant momentary or regular conduit for healing, especially if it is complemented by anointing, individual prayer and laying-on of hands. Healing initiative may also be expressed in prayers of intercession and in pastoral visiting. These ministries set the conditions in which God's grace may be realized. They also set an atmosphere in which healthy living becomes a common aspiration.

'The intersection of sacramental healing, pastoral care and the common life of Christians provides an effective base upon which individuals may experience increased wellbeing. '

There is growing scientific evidence to suggest that such a setting does indeed contribute to good health. The intersection of sacramental healing, pastoral care and the common life of Christians provides an effective base upon which individuals may experience increased wellbeing.

By common practise, clergy and lay people are involved in the support of people with mental and physical adversities. This informal pastoral support is conducted by people with only limited clinical understanding, yet can in many cases make all the difference to the flourishing of the individual. Christian theology recognises that the needs of the individual are not simply fulfilled in the context of the individual. Relationships amongst family and friends and in the wider community provide the base upon which true wellbeing can be nurtured. Churches seek to offer the context in which this sense of community can be lived.

The Christian tradition emphasises transformation of mind, body and spirit through the power of the Holy Spirit. This has often been expressed in very practical ways, especially in relation to harmful consumption of alcohol and other drugs. Federally funded groups in the United States have been recognised for their holistic approaches to lifestyle change that rely on spiritual transformation and incorporation into the community of faith. To some extent UK churches also offer spiritual and communal resources to provide individuals with a route to lifestyle change. In such circumstances, healing prayers in liturgical and pastoral settings will need to work across the boundaries between spiritual support and lifestyle transformation. Similarly, if someone is ill in the context of a lifestyle related condition, the church can pray, encourage, adjust its own social environment for greater support and engage with specific medical advice. In this way people may find greater resources to make healing a more holistic reality.

On the flipside, churches should accept that they can sometimes deteriorate into being 'toxic' environments; afflicted with catastrophic strains in relationships. To be effective with a healing ministry, they will need to pay attention that their community life is health-giving and not harmful.

The health mission of local churches

As well as his words on the healing ministry, Archbishop Temple also suggested that the Church exists for the benefit of those outside it. Whilst the healing ministry of Jesus was generally limited to those within his Jewish faith, he nevertheless offered his healing power to those who were outside this faith. Both a Roman centurion and a Canaanite woman enjoyed the benefits of this ministry. Naturally, at that point, there was no concept of the new Christian community in which people were encouraged to become believers. It was under the influence of the apostles that healing and proselytising became intertwined. Healing ministries have been used regularly as a tool for evangelistic purposes ever since.

Currently, churches are experiencing significant long term decline and need to express their mission effectively and with renewed relevance. Should they instrumentalise acts of healing for the promoting of the gospel? Some charismatic healers adopt this approach, but this is not always readily welcomed by churches and society.

Many churches choose to offer healing ministries without necessarily expecting the fuller elements of salvation to follow. Bringing health to those who suffer is a key expression of the Christian calling to love one's neighbour. Indeed it is likely that people unfamiliar with Christian teaching have a good understanding of and interest in the broad nature of healing even when they cannot make sense of the notion of salvation. The language and action of healing may thus provide a less threatening paradigm in which the Church can engage in its holistic mission. It allows for flexibility to pursue healing with spiritual renewal and salvation to a greater or lesser extent, dependent on the individual and the professional guidelines in which the activity is set.

Churches are engaged in a wide range of activities that support the needs of their local communities. Many of these address health and wellbeing. They include social and pastoral support for the elderly, Christian counselling, support groups for those with addictions, mental health or learning difficulties; soup kitchens for the homeless, fitness and diet groups etc. In certain cases, parishes in urban regeneration areas have worked closely with local government and primary care trusts to offer health services on church property, or are actively involved in health-related community based-partnerships. Inspired by the United Reformed Church in Bromley by Bow, some parishes have offered themselves as healthy living centres.

There are also examples of teamwork between religious and clinical professionals. Parish Nursing is an international, ecumenical movement that has now become well established in the UK. It commissions qualified, registered Christian nurses to work in their congregations to support health conditions

and promote healthy living. Parish nurses work alongside clergy and lay leaders in order that an holistic healing ministry be pursued not only amongst church members, but also in the wider community. They develop closer connections with local health institutions, especially those serving primary care.

It is conceivable that individual churches might choose to appoint a health team and develop a health strategy. This may encourage renewed connections between congregation, hospital and primary care through designated volunteers. A health team in each church could manage this process. This could include a parish nurse and one or two health professionals but should also engage other volunteers.

agencies and healing centres tend to exist under the banner of 'non-denominational'. They may have particular links with denominations, but do not identify themselves too closely with one church or another. For example, Burrswood Hospital has an Anglican foundation, but incorporates interests from a wide range of Christian traditions. It is not owned by the Diocese of Rochester and has independent governance.

In addition, Christian GPs have become increasingly confident in establishing overtly Christian practices. They pray with patients and offer additional spiritual support. A new generation of community health chaplains is being developed, following the example of

'Bringing health to those who suffer is a key expression of the Christian calling to love one's neighbour.'

However, church memberships are varied. Professionals often cluster in the suburbs, where they share similar lifestyles and values. Urban and rural churches often suffer a dearth of such people. There may need to be a considered effort to promote 'vocations' to serve churches in marginal settings. By way of example, some Anglican churches in Africa have developed guilds to draw health professionals as volunteers in support of their wider diocesan mission, which can incorporate the less resourced churches.

It should be noted that Christian individuals and agencies often carry out Christian health mission outside of ecclesiastical structures. In fact, denominational structures engage in only modest health related work, particularly if compared with the extensive education functions performed by the Church of England and Roman Catholic churches. Healing

Karis Medical Centre in Birmingham. Coming from a different angle, Street Angels and Street Pastors are independent structures that recruit volunteers from churches to provide care and promote healthier behaviours. Aside from hospital chaplaincy, health mission and healing ministries are generally the preserve of local congregations and Christian entrepreneurs.

The contemporary array of churches and religious organisations active throughout the country incorporates a wide diversity of approaches to health and healing. Whilst this can be considered an attractive asset to the state in its current stewardship of health services, it is more fundamentally a historic vocation of Christian faith. In implementing this healing vocation, churches offer a broad, spiritual notion of what sustains true health.

Healthcare chaplaincy: opportunities and dilemmas

As the impact of medical science grew significantly in the first half of the twentieth Century, churches began to retreat from their ownership of hospitals. Rather than being seen in their traditional roles as hostels for compassionate care of the sick, these institutions were increasingly designed as laboratories for the cure of disease. In addition, the post second world war social contract of universal health and welfare services placed responsibility for healthcare with the state rather than the churches. In order to retain a Christian presence in healthcare, churches provided chaplains to meet the religious needs of patients. These offered particular strengths that could not be met by the secularising medical establishment:

- Pastoral care rooted in attentive and inclusive listening
- A non-judgmental approach to patients and staff
- A person-centred approach to healthcare that enables the chaplain to see the person as fully human
- A widespread respect that enables a constructive critical engagement with the organisation.

However, health policy has increasingly promoted the notion of spiritual care rather than religious care. Health chaplaincy is no longer clearly distinguished as a ministry of the churches, but more a function of the National Health Service. This has happened in response to policies around equality of opportunity, respect for diversity, patient autonomy and the growing acknowledgement of holistic health care based in individualist spiritualities.

In theory, spiritual care is no longer the preserve of the chaplain, but is also incorporated into the role of nursing and other associated professions. Thus the spiritual care of patients is deemed to be a responsibility of the whole organisation rather than the chaplains who work there. Chaplaincy is therefore less connected with the national church's responsibility to the nation. It is rather a matter for the National Health Service and its spiritual care of the people. Thus the churches as institutions are further distanced from their mission in health services, even as their trained professionals play a key role in supporting spiritual care within those settings. Hospices too have in many cases moved away from their religious origins and instead focused on 'spiritual therapies'; sometime expressed alongside other complementary therapies. It is, however, a mixed picture, and there are still opportunities for relational, religious care in some settings.

This trend may be more about rhetoric than practise, since chaplains often continue to act as they have before, but there are signs of the shift in practise. There is no simple generic chaplaincy model to refer to, even with the accumulation of extensive experience in multi-faith settings. A consequence of this is that religion is subordinated. The spiritual and the religious are dealt with according to different categories. It thus marginalises the religious nature of the chaplain's role and motivation. With too much individualism in this approach to spirituality, connections with churches are undermined.

'Health chaplaincy is no longer clearly distinguished as a ministry of the churches, but more a function of the National Health Service'

Since there is no statutory basis for chaplaincy, the role is vulnerable. Chaplains have therefore sought to develop a clearer profession, with associated competencies and capabilities. These are medical models of professional chaplaincy practice and are evidence based. This repositioning seeks to justify chaplaincy afresh to society through a task-based approach. In the process, the notion of sharing the same role for both staff and patients has shifted since the staff interactions are more likely seen as a Human Resources discipline.

Chaplains can play important roles within the management of patient care, but are sometimes distanced from patients. There are a variety of job descriptions and disciplines within chaplaincy teams. In the fast moving arena of NHS policy, there are good examples of development, but often the scene shifts again so that models have little time to establish themselves. Within the chaplaincy 'profession' there are significant differences of approach in the context of these trends, yet most chaplains appear to steer a balanced course.

The church in the governance and delivery of health services

The healing vocation explicit in Christian faith naturally draws churches to bring health to the people. It can be argued that the health ecosystem of the United Kingdom is the poorer because churches largely removed themselves from the provision of medical services in the process of forming the NHS. In their place, the state and private sectors have taken up responsibility for the health of the people. Chaplaincy services have increasingly become professionalised spiritual care services that are now only loosely connected to the mission of the churches. This is far from true in other countries in Europe, the Americas, Africa and Asia, where churches remain directly involved in owning and governing a wide range of medical institutions and programmes. Most of them have an overt Christian character to their work that enriches the healing experience of patients.

Whilst the picture of church mission within the NHS is limited, UK churches nevertheless find themselves more engaged with the promotion of health than is commonly realised.

At congregational level there are a wide range of activities that promote health and support disease. The Church of England recently asserted the following:

Through the Church's pastoral engagement with individuals, families and communities, through its involvement in healthcare chaplaincy and through its ongoing work in the community in advocacy, health promotion and healthcare delivery, the Church is uniquely placed to contribute positively towards the creation of a society healthier in body, mind and spirit. (Health Care and the Church's Mission, GS1857)

Recent health reforms have opened space in which the contribution of churches to the health system might be amplified. It is important, however, that churches understand the context and nature of reforms and that they respond in ways consistent with the core principles of Christian mission, rather than simply being opportunistic.

New trends in health and welfare systems

Research emerging from Uppsala University on welfare and religion in Europe notes that cradle-to-grave care has been transposed from a religious vocation to a technocratic secular mandate. With signs that the state can no longer deliver contemporary demands on this mandate, governments across Europe are questioning whether churches should re-engage.

European countries have a range of welfare models according to their particular political histories and religious traditions. For instance, following the Second World War, the German church reappraised its traditional Lutheran two-kingdoms theology and negotiated a post-war division of labour with the state that offered a significant role for the church in welfare and health services. The Catholic focus on subsidiarity in Italy emphasises the role of the family in welfare and care. The liberal, individualist model of Switzerland implies a more marketised model dominated by insurance. The Uppsala research notes that as churches are increasing their contribution to welfare systems, these inherent political and religious characteristics shape their response. For example, the Catholic Church in France can engage with the poor and under-supported, because of its own marginal position within French society.

During the past 30 years, there have been major shifts taking place in health and welfare systems across Europe and the wider world. The post-war social contract between state and citizen for comprehensive, universal health and welfare systems has been found wanting at various levels:

- The sheer weight of dependency inherent in the system could never have been imagined. The costs of professionalised care in the context of an aging population in a post-industrial economy are beyond its capacity to bear.

- The inefficiencies and corruptions of single state service providers are no longer acceptable. Mixed economies of providers offer greater levels of innovation and value.

- The relational bonds in the nature of health and social care were undervalued. Social capital within communities has diminished, leaving individuals who are plagued by loneliness.

- Initiative for health and wellbeing is no longer sufficiently conceived as the responsibility of the individual within community. The 'nanny state' is derided even as people rely on it.

In response to these tensions, the United Kingdom has passed successive waves of reforms. The homogenous state provider model of health was initially reformed in the cause of saving money. New Public Management models of contracting elements of service provision were designed to lower costs and increase efficiencies. People were encouraged to think of themselves as consumers of health services to encourage better customer service and to shift the patrician tendencies of the medical professions and health service managers.

More recent reforms have focused on 'public value'; the notion that services such as medicine should seek public goods beyond that of cost efficiency. Thus there is a greater emphasis on service provision within the community, where people are likely to be best supported. The adoption of 'co-production' models imply that people themselves have much to offer in order to improve their health, and encourages them to respond more proactively to the resources of medicine. The medical professions are encouraged to resource the decision making capacities of patients; to enhance their confidence to take initiative and responsibility. Health service managers and commissioners are looking at ways in which communities can be engaged in shaping and even owning services. This higher level of interactivity shifts the location of health services from institutions to community systems and opens up space for churches to re-engage in health service strategy and implementation.

'Health service managers are looking at ways in which communities can be engaged in shaping and even owning services.'

Amidst these reforms, the notion of professionalism still holds sway in medicine against the backdrop of increasingly managed approaches to health. This is significant since an organisational rationale based on the mobilisation of clinical professionals shapes significantly both the nature of health system design and the notion of healing. The doctor-patient relationship has been at the heart of the healing paradigm since Hippocrates

formulated his oath in Ancient Greece. Ideally, medicine is a vocational calling, similar in character to that of the priest in which trust and expectation is placed. However, as was noted earlier, the medical profession has not adequately maintained the holistic nature of this relationship in the face of scientific advance. In addition, the advantages of professional application of knowledge and experience are increasingly questioned by the rationale of team working and task shifting. The notion of professionalism faces a range of challenges to its foundational principles.

The processes and rationales for health reform are complex and demanding. The sympathies of the general population are often stirred by entrenched interests in reaction to the latest round of NHS reorganisation, and it remains challenging to bring wisdom to bear on the political debates that swirl around in the media. Few voices are willing to rise above the particular populist issue of the moment.

In February 2012, the Church of England chose to pass a motion through its General Synod in response to NHS reform. However, despite a briefing that addressed some of the issues surrounding the reform, it chose only to pass a rather open-ended statement, such that the church would:

(b) call upon Her Majesty's Government to apply as the test to any proposed changes to the NHS whether they are best calculated to secure the provision throughout the country of effective and efficient healthcare services provided free at the point of delivery and according to clinical need.

The founding of the NHS through public financing has given medicine in the UK its particular character, political symbolism and loyalty. Popular commentators regularly attribute religious feeling to the NHS despite the fact that many different yet successful models of health service delivery operate throughout Europe. In proposing the aforementioned motion, a conflation was made between the institutional capacity of the NHS and the health of the people:

The NHS is not of course the preserve of the Church, but such is its importance for the health and well-being of tens of millions of people that it is incumbent on the Church to speak up for the maintenance and development of an institution that has served the people of this country well for more than 60 years. It is true that it may reasonably be argued that it is an institution in need of some medication to return it to robust health, but our concern must be to ensure that the medicine being prescribed at present by Her Majesty's Government cures rather than kills the patient. (Bishop Mike Hill, General Synod, February 2012)

Amidst the many changes affecting health services in the UK, it is important that churches gain in confidence in evaluating the likely impact on the health of the people. Moreover, as these changes open up opportunities in local health ecosystems, churches have the chance to reconnect their healing vocation with statutory service provision.

Opportunities for the churches

The new powers of Clinical Commissioning Groups (CCGs) may open opportunities for both advocacy by churches and for partnerships in service delivery. These powers allow GPs to promote a wider notion of care, and to draw in appropriate community based actors to meet the complex clinical management challenges of chronic disease. To date, the operation of CCGs remains untested. The commissioning process may in time engage communities in service provision, or, due to inadequate resources, may defer to professional interests. It may take considerable commitment by churches and community leaders to monitor and influence commissioning so that new patterns might emerge.

'... churches can be amongst the most creative and committed providers of services.'

In making this influence effective, churches will need to adapt their mode of presence in communities so that they can facilitate collective processes. Churches often have the power to convene varied interests to deliberate. This influence may be crucial to a healthy interaction between commissioners and people. It may also promote design and implementation of community owned

mechanisms by which services are delivered. However, in taking such a path, churches should not be naïve about the political and professional interests at stake.

Additional reforms currently being rolled out by government provide enhanced opportunities for churches to be engaged in the governance and monitoring of the NHS and Social Care. These include Healthwatch, patient groups in GP Practices, the role of carers and others in the 'Personalisation Agenda' in social care, and Dignity Champions. There may also be opportunities for churches to propose members to be on the boards of Foundation Trusts and Health and Wellbeing Boards. Indeed, the Archbishop of Canterbury, Rt Revd Justin Welby, was chair of a hospital trust during his ministry in Coventry.

Perhaps most ambitiously, the capacity for 'any willing provider' to bid for clinical services may also open opportunities for churches to involve themselves directly in the practice of medicine.

There are many opportunities open to the churches. They therefore need to reflect on what roles they should play in medical services and health promotion. On the one hand they will need to add significant value to a particular role, and on the other hand they will need to ensure they are sufficiently well organized in order to meet the challenges of managing these roles. The role of churches in education indicates that this is possible, and that churches can be amongst the most creative and committed providers of services.

Missional initiative in health: theological and organisational considerations

Since churches are being drawn back into health and social welfare, they will need to be proactive in re-forming their mission accordingly. Whilst it is tempting to equate these policy changes as a cynical political ploy to reverse the redistributive initiatives of left-leaning governments, churches should reflect positively on the opportunities for themselves and for the wider society in the renewal of associational localism. But in doing so, they will need to avoid simply reacting to government agendas, and reflect on how they can reconstitute their roles intentionally according to missional and theological priorities. Given the continuing commitment to the healing vocation of the Church affirmed by Bishops and other church leaders, this growing mixed economy of health actors at local level should enjoy widespread support amongst churches.

In re-forming their role in health, churches need also to reflect on the mixed economy of religious life in society. Church leaders are well aware they no longer operate in a hegemonic mode. Indeed it is doubtful that the Church of England has the resources to maintain its universal mission in the country, which is now under a great deal of strain. As Grace Davie's

research indicates, religion in Western Europe has been seen as a public utility that people opt out of rather than into. The notion of vicarious religion is useful in this context and suggests that the wider population is on the whole grateful to the active minority who keep the church alive. However, this form of religion is in decline, though faster in some places than others. Gaining competitive advantage in this context, independent Evangelical and Charismatic churches have emerged to play an increasingly prominent role in public life. They are responding to a religious market within which people choose to engage according to their preferences rather than in deference to established models of state church. Such a shift may prompt a re-forming of national Christian mission in a more collaborative manner with the wide range of other religious groups, working together in local networks.

A further trend to note is in the entrepreneurial initiatives of Christian people who choose to engage faith in their enterprise. Examples include the GP practices that expressly provide for spiritual care, and charitable foundations such as Street Pastors that draw Christian volunteers to support the health of the most vulnerable. Emerging forms of chaplaincy are in some cases following a market model. As social businesses, they have contracts for spiritual care with institutions such as airports.

Inevitably these trends raise questions about the foundations of ecclesiology, and require churches to address the theology and practicality of organisational adaptation. The capacity of congregations for local action is not necessarily reflected in the ability for denominations to act institutionally. There are some missional activities such as Fresh Expressions that emerge from the centre and connect with the local, but these are the exception. The organisational functions of denominations will want to help local churches evaluate what is possible and then accept their limitations. Churches have not the capacity to solve all of society's problems, but are nevertheless called to initiate signs of the 'Kingdom of God'.

The value-added capabilities of churches

The presence of churches in communities is generally stable. Their organisational memory and interconnections are usually extensive and deeply relational compared to other organisations active in local matters. Because of their essentially local governance, the mission of churches can be responsive to shifts within their communities. In particular, churches can crystallise and sustain community-based initiative. The convening power of church leaders along with the faithful hospitality of church community provide a dependability and capacity to sustain such initiatives. They are attentive to issues of local justice and committed to the common good. Their commitment to pastoral and associational relationships promotes healthy community. Their work within localities can incorporate and encourage innovation but yet at the same time provide anchors for identity and belonging. They are increasingly aware of the need to empower people and are capable of both confrontation and negotiation. Many churches practice a ministry of healing that is complementary to medicine. In so doing they may promote 'communities of interpretation' and sustain a non-reductive vision of what is a healthy person.

Churches have long understood what it means to offer a prophetic voice in society for the needs of the most vulnerable. They are increasingly aware that in order for their voice to be prominent and effective, they need at the same to be engaged in local service

delivery to these individuals and communities. Churches will naturally seek to raise the voice of the most marginalised and to ensure that these are serviced well rather than forgotten.

There may be a popular perception that religious institutions act conditionally in order to evangelise. This needs sensitive and transparent handling where a Christian institution is in danger of perceived partiality and exploitation of the vulnerable. With this proviso, churches are well placed to manage care either according to the local 'amateur community' model or to the 'professionalised agency' model. They may even be adept at

'churches can crystallise and sustain community-based initiative'

generating carefully designed hybrid models. This flexibility offers a great deal of potential to address current challenges in health and social care. Carrying with them these assets and capacities, churches can facilitate and help sustain communal co-production in health.

Examples are already emerging that demonstrate how churches can re-engage with health authorities. In learning from these experiences, churches will increasingly improve their wisdom in negotiating partnerships. There may in some instances be opportunities in which a contractual relationship is effective to deliver certain services, but generally the church will want to offer its human resources and social capital to some joint working, requiring some in-kind training and perhaps some modest financial support. For instance, as the responsibility for

public health moves back to local councils, churches will want to build relationships with officers in order to play their part in promoting health in their communities. To support this, public officials, clergy and volunteers will need training to adapt church mission to a partnership model with the health sector.

It is common for church-initiated projects to slip away into independence and detach from their original ownership. Churches should consider how collaborative projects can be empowered and yet remain identified with and inspired by their religious foundation.

Amongst the many examples from around the world, the Episcopal Diocese of Texas has been particularly entrepreneurial. It has established an agency in Houston that has developed a class leading community health data tool. With this tool it now provides leadership in the city for the development of a wide range of health services. For example, following an analysis of mortality rates for breast cancer, it drew together a range of donors and delivery partners to provide locally based clinical services to encourage early treatment for the uninsured.

Case Study: Burrswood Hospital, Kent

1948 was an auspicious year in health care. In this year, as the NHS and WHO were established, Burrswood Hospital was founded. The initiative lay with Dorothy Kerrin, who had experienced significant ill health herself and discovered through it her gift of healing. She brought 3 principles to bear upon this new place of healing: Heal the sick - Comfort the sorrowing - Bring faith to the faithless.

Originally a place of spiritual ministry, it is now a registered hospital with an integrated team of nurses, chaplains, doctors, physiotherapists and counsellors. The shared working and confidentiality of the team provides a place of safety where healthy relationships with God, creation and each other are the key to a person's healing. Burrswood is committed to an equality of relationship between doctor and patient, which allows for a shared journey. In this setting, the needs of the patient are considered as a whole, and not isolated into their respective parts. Indeed, the current model at Burrswood was much inspired by the hospice movement.

Body, mind and spirit can be addressed at Burrswood without language about God for those who do not express faith. Physiotherapy and meditation techniques can be utilised. This almost always leads to a positive experience. Normally, patients are around 50% professed Christian. The staff have a good deal of experience dealing with the natural variety of people who come, which promotes a diverse approach to the Christian character of Burrswood.

Burrswood has a service level agreement with a hospital trust to provide step-down care from orthopaedic treatment. This helps to relieve pressure on the trust for rehabilitation. This will involve Burrswood in an adaptation of practice for the 3 – 5 day contracted stays. This will not allow it to act in quite the same way to meet its approach to whole-person care, but its adaptation of practise may provide a context in which its concept of care can be developed for statutory settings. This may then be applicable widely.

Burrswood appears to offer an almost unique example that can demonstrate a reintegration of faith and health. However, its generous person-centred medicine and prayer demands continual financial subsidy. It thus relies on considerable charitable support. Whilst this model struggles with sustainability, it nevertheless provides an example of the added value of Christian care amidst a generous community of churches.

Comparative study: Church of Norway

In Norway, health care services are provided predominantly by the state. The Church of Norway is largely detached from the health system apart from retaining ownership of 3 general hospitals and 3 specialised hospitals. In addition there are a number of social welfare institutions that pay particular attention to the elderly and those with addictions. These have survived despite the evolution of the country's welfare system rather than because of it. The church hospitals are highly respected but have often found themselves as uncomfortable anomalies rather than treasured assets in their interaction with public bureaucracy. However, despite the struggle, they are well integrated into the public system.

The church undertakes its health and social care work under the concept of 'diakonia'. This is considered as gift and service by the church for the benefit of society, and is distinct from the evangelistic outreach of the church. Church-related university institutions train professionals to undertake and manage these diakonal service programmes. In relation to medical care, the programme 'Diakonal values in practice' has been piloted at the Diakonhjemmet Sykehus in Oslo. This programme provided training for all staff in this church hospital. It included the development of a catechism to promote self-understanding and identity for the Christian character of the hospital. It promotes holistic care as a task in which all staff are involved, particularly the nursing staff. Each ward has a diakonal nurse who spends 20% of her (they are all female) time addressing these values. They maintain continuous training for the other staff on their wards and facilitate diakonal practice and values amongst patients.

Norway's health system is currently under pressure and is struggling to meet popular expectation. There are trends towards private care among those who can afford it. There are various reform processes underway, and the church is in dialogue with government on this. The aim of the reform is to provide the right

treatment in the right place, and relies on a stronger local infrastructure. This will devolve budgets and save costs, but will also open territory for new approaches to providing care. It may allow consideration of spiritual and social assets for healing. The reforms open opportunities for diakonal institutions to get involved, allowing the church to address loneliness and other factors that affect people's health.

80% of the population of Norway are members of the Lutheran church, which was the state church until 2011. There is only limited religious activity beyond this. However, the recent influx of immigrants has opened new space in which religious issues are apparent. This is particularly true in relation to Islam. This emergence of religious diversity is impacting the development of health and welfare services. A deeply secular country, religion in Norway struggles to meet this challenge. In the face of laws prohibiting health and welfare rights to illegal immigrants, church hospitals offer treatment on a charitable basis. This is both a prophetic witness and an act of civil disobedience, and is one way in which diakonal values are expressed.

Chaplaincy exists in public hospitals in Norway. This has been growing over the past 25 years. The hospital and bishop appoint. Otherwise, parishes are rarely engaged with hospitals. Health is not generally considered a priority by parishes.

A contact forum for church and health authorities was formed in 1999. It considers the points of cooperation between health services and church and seeks further development, particularly in relation to the elderly, psychiatric services and health promotion. It also allows for reflection on values. A government white paper, 'On Values for the Norwegian Health Care Services', was published in 2000 following discussions in the forum. Among the main points were the following:

- It called for a holistic approach to health
- It pointed to priorities in health care
- It discussed the challenge from alternative medicine
- It discussed the role of the church and the diakonal hospitals

The paper was well received but did not lead to any practical steps. Further discussions ensued. A health minister took a particular interest in the forum at one point and raised its profile. However, the forum has since had mixed fortunes. It is currently now back in action in the face of the new period of reform.

Church leadership in Norway is only recently becoming more aware of the opportunity for the church to re-engage in health and welfare. Traditional Lutheran theology provided only limited capacity for the church's presence in public space. Medical care has continued under the church's ownership without adequate attention to its significance. A process of disestablishment is now underway, which opens up new questions about the roles of the church within society. The 2014 church assembly may well have health and the church as its main topic for discussion.

Norwegians are generally receptive to service delivery by non-profit groups and are aware of the need for values, caring and humane quality. This may be an important moment for new thinking and practice. It may even form part of a key resetting of the mission of the church in society. There is a growing awareness that clear ecclesial character needs to be present amidst diakonal institutions. The church needs to be proactive in this process of reform by raising new thinking. It must present itself as a serious partner.

Speakers and presenters

Speaker	Background	Presentation
Dr. Ross Bryson	GP, Professional Association of Community Healthcare Chaplains	1. Spiritual and religious care in the NHS 2. Community Health Chaplaincy
Revd Richard Coles	Vicar of Finedon and presenter on BBC Radio 4's Saturday Live	
Prof Grace Davie	Emeritus Professor of Sociology at Exeter University	1. Faith and secularism in health services: What are appropriate boundaries? How do we define and implement 'spiritual' and 'religious' care. How can health services mediate religious interests in multi-faith environments? 2. Spiritual and religious care in the NHS
Dr. Neil Deuchar	Consultant Psychiatrist, Medical Director (Mental Health) of NHS Midlands and East	1. Spirituality and Public Health: developments in Birmingham 2. Real Deal: How Ministry for Vulnerable Adults, Neighbour Schemes, Health and Social Care and Industry work together in Birmingham for Destitute People
Dr. David Fine	CEO, St. Luke's Episcopal Health System, Houston	Insights from a diocesan health system in the United States
Professor Peter Gilbert	Emeritus Professor of Social Work and Spirituality , Staffordshire University	Spirituality and Public Health; developments in Birmingham
Prof John Hull	Honorary Professor of Practical Theology, Queens Foundation	The experience and theology of disability
Dr. Beate Jacob	Consultant, Theological Studies on Health and Healing, Difaem (German Institute for Medical Mission)	Congregations and mental health in Germany

Jim McManus	Director of Public Health, Hertfordshire	The church in the governance and delivery of health services
Revd Dame Sarah Mullally	Canon Treasurer, Salisbury Cathedral, Former Chief Nurse	Health, healing and the congregation
Rt. Revd James Newcome	Bishop of Carlisle	Integration: The way ahead
Revd Dr. Kjell Nordstokke	Professor of Theology, Diakonhjemmet University College, Oslo	The practice of diakonia in Church hospitals, Norway
Janette O'Neil	CEO, Us	Community process and primary care in Africa
Revd Dr. Russ Parker	Director, Acorn Christian Healing Foundation	Health, healing and the congregation
Rt. Revd John Pritchard	Bishop of Oxford, President of Guild of Health	1. Lessons from the church's ministry in education 2. What does prayer and religious ritual achieve in the healing of the person?
Dr. Peter Rookes	Independent researcher, international Christian health services	1. Healthwatch, Clinical Commissioning Groups and NHS Trusts: Do people of faith have a role? 2. Christian health services in developing countries: Are there any lessons for us?
Revd Canon Dr Andrew Todd	Director, The Cardiff Centre for Chaplaincy Studies	1. Spiritual and religious care in the NHS 2.Healthcare chaplaincy: How can churches navigate the debate about the nature and purpose of spiritual care and religious care? What are the implications for understanding the interrelationship between service, dialogue, mission and evangelism?
Dr. Gareth Tuckwell	Former CEO of Burrswood Hospital, Trustee of Macmillan Cancer Support	Health, dying and human flourishing
Rt. Revd David Urquhart	Bishop of Birmingham	
Revd Dr. Helen Wordsworth	National Coordinator, Parish Nursing Ministries UK	The healing ministries of the church amongst individuals and communities

Workshops and breakout sessions

Speaker	Background	Presentation
James Ashdown		How can Christian community be supportive to the breadth of people whose lives may be limited by mental, emotional or physical factors?
Lucyann Ashdown	Midwife, Priest in Charge, Blaenau Irfon and Irfon Valley Parishes, Church in Wales	Women's health and reproductive services: challenges and opportunities
Revd John Atkinson	Chair of Churches Together for Healing, Advisor to the Methodist Church on Health and Healing	Health mission – healing ministry: On what basis is this the vocation of the Church? What does the Christian faith proclaim about health and how does this shape the ministry of the church?
Revd Elizabeth Baxter	Executive Director, Holy Rood House	Therapeutic communities: What makes for a healing environment in religious community?
Adam Bonner	Director of Community Mission, Liveability	Promoting happiness and wellbeing: Congregational resources from Liveability
Dr. Gail Bray	Executive Director, St. Luke's Episcopal Health Charities, Houston	St. Luke's Episcopal Health Charities, Houston: The public health and health promotion roles of the Diocese of Texas.
Dr Ian Campbell	Facilitator, international health and mission; travel health clinician. Affirm Facilitation Associates/ InterHealth Worldwide	How can churches crystallise collective approaches to health in their communities?

Revd Bob Callaghan	National Coordinator, Inclusive Church	Churches as Healthy Living Centres: The Kingdom or white elephants?
Revd Jonathan Clark	Director for Premier Life at Premier Christian Media	How can healthcare teams and healing ministries be harnessed to achieve a good dying rather than seeing death as failure of treatment or prayer? How can barriers of mistrust and the fear of different objectives be broken down to give birth to a new community of carers?
Hannah Clifton	Chair, ME Trust	How can the church support the voice of the patient and make it more prominent?
Revd Paul Collier	Vicar, Copleston Centre, Peckham	Church based community mental health services: Copleston Centre
Revd Professor Christopher C H Cook	Professor of Spirituality, Theology & Health, University of Durham	1. Health and healing: formation and education 2. Towards a theology of health, dying and human flourishing
Terry Drummond CA	Bishop of Southwark's Adviser on Urban and Public Policy	In what ways can the Christian community seek positive change in society to promote well being and good health? How can it support care at the end of life?
Revd Dr. David Evans	Director for Community Engagement & Health, Us	Hands on Health: A methodology for community led initiatives in health
Dr. Pablo Fernandez	Head of Graduate Ministries, Christian Medical Fellowship	Praying with patients.
Revd Christine Garrard	Chaplain, Burrswood Christian Hospital	What does it mean to be a Christian health institution? How does faith influence the way it is run, the way it relates to service users and the way Christian values are communicated?
Dr. John Geater MBE	International Director, PRIME	Promoting a common understanding of healthcare in the education of doctors, students and church leaders
Revd. Dr Alison J Gray	Consultant Psychiatrist and Anglican priest	Health and Religion: Insights from scientific studies

Dr Jamie Harrison	William Leech Fellow in Applied Christian Theology, St. John's College, University of Durham. General Practitioner.	Where is true wisdom to be found? Given the increase in autonomy, education and access to information, how are we now masters of our own health? Given that information is not wisdom, how can the individual benefit from communal wisdom to support health? What does the individual within community now need from the medical profession and how should the relationship between doctor and patient adapt?
Richard James	Chief Executive Officer, YMCA London South West	YMCA: Promoting health amongst young people
Revd Elizabeth Knifton	Chaplain, Acorn Christian Healing Foundation	Congregational healing ministries: What part do they play in promoting health and how can they be structured to greatest effect?
Revd Christopher MacKenna	Director, St Marylebone Healing & Counselling Centre and Clinical Director, The Guild of Health	Human flourishing for people with severe enduring mental illness.
Dr. David McDonald	Consultant Psychiatrist, Church of England advisor on deliverance and health	Medicine, miracles and placebos: What should the church teach about healing?
Revd Dr. Brendan McCarthy	National Adviser on Medical Ethics and Health and Social Care Policy, Church of England	Care for the dying in the face of the heightened capacity to extend and preserve life.
Dr. Huw Morgan	Executive and Senior Desk Holder, PRIME	Promoting a common understanding of healthcare in the education of doctors, students and church leaders
Revd Paul Nash	Head of chaplaincy, Birmingham Children's Hospital	Enhancing the religious and spiritual wellbeing of sick children and young people
Major Dr Dean Pallant	International Health Services Coordinator, The Salvation Army International Headquarters	Keeping Christian health services Christ-like: Resources for the task
Heather Roy	Secretary General, Eurodiaconia, Brussels	What are the implications of being a 'partner' or 'contractor' in the delivery of church based health services funded by the public sector?

Revd Ben Rhodes	Spiritual Care Lead and Chaplaincy Team Manager, King's College Hospital NHS Foundation Trust	What might be the role of the church in supporting people as they navigate local health treatment and acute hospital treatment?
Dr. Mike Sheldon	GP, Co-founder of Wholecare	The medicalisation of health care leads to a focus on improving human biomechanics. What is needed to support the health of the whole person?
Daniel Singleton	National Executive Director, Faithaction	1. What might a Christian voice say about the challenging choices that will have to be made concerning the future commissioning and provision of health services? To what extent can churches help prioritise the most vulnerable? How can they orientate institutions to ensure they proactively seek out the lowly sick, not only to serve but also to empower and to be shaped by? 2. Clinical commissioning: A new opportunity for church based health services? A new opportunity for churches to influence the nature of commissioning?
Morten Skjørshammer	Former Chief Executive, Diakonhjemmet Sykhus, Oslo	Diakonhjemmet Sykhus, Oslo: A programme of diakonal training for all staff
Dr. Rob Waller	Consultant Psychiatrist and founding director of Premier Mind and Soul	Minds mediate well-being and frame the experience of health. What expectations do we have for mental health and the healing of minds?
Helen Walley	Acorn Christian Healing Foundation	The Importance of listening in Christian Healing Ministry
Dr. Paul Worthley	Senior Physician, Burrswood Christian Hospital	What does it mean for a Christian to express a healing vocation in the secular world of medicine? How do churches support and integrate these vocations into their collective mission and ministry?